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STATE OF NEW YORK

MEDICAL CARE  
In New York State  
1939

REPORT

*New York (State)*

of the

TEMPORARY LEGISLATIVE COMMISSION  
TO FORMULATE A LONG RANGE  
STATE HEALTH PROGRAM

TRANSMITTED MARCH 28, 1940



ALBANY

J. B. LYON COMPANY, PRINTERS

1940

STATE OF NEW YORK

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TO FORMULATE A LONG RANGE  
STATE HEALTH PROGRAM  
TEMPORARY HEALTH COMMISSION

TRANSMITTED MARCH 22, 1940

ALBANY  
J. B. ALBANY, CLERK  
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## LETTER OF TRANSMITTAL

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ALBANY, N. Y., March 28, 1940

*To His Excellency, the Governor of the State of New York, and to the Honorable Members of the Legislature of the State of New York:*

The New York State Temporary Legislative Commission to Formulate a Long Range State Health Program has the honor to submit for favorable consideration a comprehensive report on Medical Care in New York State, 1939, summarizing studies, findings, analyses and recommendations prepared pursuant to the powers and duties conferred upon it by chapter 682 of the Laws of 1938 and chapter 933 of the Laws of 1939.

The Commission has embraced within its deliberations not only matters requiring immediate attention, but also problems requiring further thorough study, before a long range health program directed toward all groups of the population can be formulated and carried out with efficiency and economy.

Respectfully submitted,

LEE B. MAILLER, *Chairman, Assemblyman*  
WALTER J. MAHONEY, *Vice-Chairman, Senator*  
ROBERT F. WAGNER, JR., *Secretary, Assemblyman*

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\* Deceased, April, 1940.



## INTRODUCTION

The New York State Health Commission, with full awareness "that the health of the inhabitants of the State is a matter of State concern; that adequate medical care is an essential element of public health;" and, that the other objectives established by the Legislature, in creating the Commission, are essential to the formulation of a long range health program, decided that the greatest progress could be made by devoting the second year of its existence to an intensive study, at first hand, of the problems confronting: individuals in need of medical care; the physicians and hospitals who attempt to meet these needs; and, members of families or representatives of agencies with moral or legal responsibility for paying the medical and hospital bills.

*Last year*, the Commission, through public hearings, individual conferences, and studies, became aware of the tremendous complexity of the many factors and situations involved in the existing methods for the distribution of health and medical services both on an individualized and collective basis. An attempt to correlate and summarize the variegated wealth of information assembled by the Commission revealed the highly controversial nature of many of the factors and observations, despite an apparent unanimity on the part of individuals and groups with respect to the essentials of preventive and curative medicine and the need for their practical application.

It was felt therefore that due to limitations of time, and to bring order out of this apparent chaos, an attempt should be made to crystallize present trends and desirable future developments in two sets of recommendations each covering a ten point program.

Hence, the Preliminary Report<sup>1</sup> of the Commission consisted of Preliminary Recommendations and Recommendations for Future Study presented against a pictorial background, county by county, of the medical and health resources of the State of New York: showing *what* they are, *where* they are and a slight indication of *how* they are used. Certain trends were traced in the move toward decentralization of the professional and technical services and facilities of the State agencies in the three fields: preventive or health services; institutional or hospital services; and curative or public medical care services.

*This year*, attempts have been made by the Commission to get at the heart of the problems involved in the distribution of medical services to persons who need them, by designing specific studies which would secure pertinent factual data with respect to specific areas in this broad field.

<sup>1</sup> Legislative Document (1939) No. 97.

These studies included an evaluation of the volume, type and, in some instances, the quality of professional and institutional services requested by or provided to individuals in the lower income groups.

A careful study was also made of a representative sample of individuals who had experienced treatment in hospital wards, together with an analysis of the economic and medical circumstances involved in the illnesses which brought them to the hospital. The central position of a general hospital in the distribution of medical care was appraised, with due consideration given to the organization and training of the hospital staff.

Throughout, an attempt was made to ascertain the individual rôles and interrelationships of the voluntary and governmental agencies now assuming responsibilities in meeting the medical care requirements of the individuals in the various groups under observation.

A pioneer attempt was made to appraise the quality as well as the quantity of the medical care experienced by patients prior to admission to hospital wards for the treatment of a catastrophic illness. Light was thrown on this element of quality by inquiries with respect to: extent of self-medication; delay in securing a physician and reasons therefor; and the type and extent of diagnostic procedures employed by the attending physician. Consideration was given to the mechanisms for the distribution of medical care to the indigent and medically indigent by the public agencies responsible, in view of the increasing rôle which these agencies play in the provision of medical care for persons in the low income groups.

The Commission recognizes the generally accepted concept that "preventive and curative medicine cannot be separated on any sound principle and in any scheme of medical service must be brought together in close coordination." This is particularly true with respect to diseases and conditions for which specific methods of treatment and control have been established, and for which the public health importance to the community of successful treatment transcends considerations of the economic status of the individual. These diseases and conditions include pneumonia, cancer, syphilis, tuberculosis, dental caries, drug addiction and physical defects of childhood.

Careful consideration was given by the Commission to specific mechanisms proposed or established for the distribution of medical care and health services on a budgetary prepayment basis among the groups of the population who find difficulty in meeting the burdens imposed by the hazards of illness. Budgeting the costs of medical care for large groups of the population usually involves the concept of insurance, compulsory or voluntary, to spread the risk.



The varied financial contributions involved in meeting such costs may be paid individually or in combination by the insured, industry and the State. To what degree the use of the insurance principle as a basis for paying for medical care will affect the quality of the care distributed is highly controversial.

The ability of prepayment plans, devoted solely to a specific portion of the care and service necessary, in a complete well-rounded health service, to meet the needs of the individual on a basis which he, industry and the State can afford to pay, is also open to question. Although piecemeal activity in each field may be valuable as experimentation to gain experience in the cost of distributing various types of medical and health services, without, however, overall planning, the result will be a patchwork of overlapping and expensive services which will eventually have to be coordinated or combined in the interest of efficiency and economy.

A long range State health program should "build for the future, without undue intervention with local autonomy, viewing both central and local problems as parts of one whole."<sup>2</sup> Such a program should be "a means rather than an end, an improvement in the machinery of government. It cannot be a substitute for medical science, for the local authority, or for voluntary enterprise, nor even for that impulse of public assent without which all instruments of government will prove useless."

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<sup>2</sup> Paraphrasing: Sir George Newman. *The Building of a Nation's Health*, London, 1939, pp. 126 & 127.

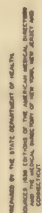
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The Commission is under deep obligation to a great many individuals for assistance, counsel and guidance given in the preparation of this work. Grateful acknowledgment is made here to them and to the institutions and agencies, both public and private, who have compiled and presented information, suggestions in connection with the studies included in this report.



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## SUMMARY OF PROGRESS

### Health Commission Recommendations

The Commission in presenting its Preliminary Report<sup>1</sup> agreed that more progress could be made in the development of a long range health program if emphasis were placed upon the resources available and well considered recommendations for immediate action and for future study. It seemed obvious in all of the discussions that the health objectives set forth in the statute creating the Commission were universally acceptable but that the procedures suggested for achieving such objectives were varied and controversial. A detailed presentation of the divers facts and opinions presented, both in the hearings held by and the deliberations of the Commission, was not attempted because of the wide disagreement among the participants. This decision was further bolstered by the statement of the Governor, the Honorable Herbert H. Lehman, in his 1939 annual message to the Legislature, when he said, "It is inadvisable for the State immediately to launch upon a program which will involve very large expenditures without first making a thorough study of all aspects of the problem."

Before presenting the findings of this year's studies which were devoted to an intensive analysis of specific aspects of health and medical care in New York State, the recommendations made last year will be recapitulated seriatim with brief progress notes summarized under each recommendation.

### Preliminary Recommendations

1. Establishment of informal interdepartmental committees or councils, on State and local levels—to coordinate health and welfare, preventive, diagnostic and curative services conducted by the several governmental departments or agencies (Health, Welfare, Mental Hygiene, Education, Correction, etc.). Full use should be made of authorized representatives of the organized medical and related professions, for advice and counsel in professional matters.

**Comment (PR-1).**—Continuing studies of the activities and administrative structures of State departments responsible for administration of various aspects of health and medical care reveal the desirability of establishing a representative interdepartmental coordinating council on a State level to guide the health activities in the various State departments. An advisory committee composed of representatives of the medical and related professions and agencies, should be consulted before any steps are taken toward coordination of the health functions of the several departments. This should lead to the discovery and elimination of expensive duplication of services with a resultant increase in efficiency and economy. At any local level where similar complexity and duplication of health activities exist, a similar policy of coordination should be followed.

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<sup>1</sup> Legislative Document (1939) No. 97.



2. Provision for uniform record keeping and compilation of municipal expenditures for public health and medical care—so that a tabulation by the Bureau of Municipal Accounts of the State will immediately reveal expensive duplication and expedite future planning to permit more effective and economical use of public funds.

**Comment (PR-2).**—Studies by this Commission, as well as other State and Federal agencies, have revealed the difficulty and the practical impossibility in ascertaining under existing methods of fiscal reporting, actual expenditures of public funds for health and medical care and reliable cost data for comparative purposes. Increased Federal and State participation in these fields has given great impetus to the development of standard schedules for reporting health expenditures on Federal, State and local levels. A standardization of the fiscal report forms for health and medical care expenditures is imperative on both a State and local level. This can be achieved by a collaboration between the agencies responsible for State administration of health services and expenditures, the Division of State Planning, the Division of Audit and Control and the Budget Director.

3. Extension of public health education on a broad base, to provide for every citizen full information on the availability of health and medical facilities and services. Organized voluntary lay and professional groups should actively participate in this statewide program.

**Comment (PR-3).**—Public health education should provide each individual with the ability to recognize the necessity for medical attention and a knowledge of health and medical facilities available to him. A study, by the Commission, of patients discharged from hospital wards in New York State, throws a new light upon the variations in the extent to which present methods of public health education reach individuals in the lower income groups who experience catastrophic illness. The extent to which sick persons fail to recognize the necessity for medical care, the degree to which they resort to self-medication and the extent to which there are both personal and economic barriers to the prompt and full use of competent medical diagnosis and care—as revealed in the study—are indices of the failure of public health education to reach the individuals who are most in need of it.

4. Expansion of full-time trained public health personnel and services to provide a more equitable coverage for each county of the State, and an extension of post-graduate education of practicing physicians in the practical application of proven advances in the treatment and control of certain diseases and conditions of public health importance.

**Comment (PR-4).**—Great progress has been made in the training of full-time public health workers and many localities in the State have benefited by increasing availability to them of such personnel. This program conducted with State and Federal aid has been greatly strengthened by the interest and activity of the State and county medical societies in sponsoring and conducting short post-graduate seminar courses for practicing physicians, designed to expedite the application of advances in medical science, in the treatment and control of diseases of public health importance. A knowledge of the advances in both preventive and curative medicine has been acquired by many physicians in the State under this broad training program. Through the efforts of the Speakers' Bureaus of the county medical societies in interpreting these advances to the general public, a great opportunity is provided for direct application of this new knowledge. However, the supply of properly trained public health personnel is so inadequate in relation to the need, that both State and local governmental agencies should not be hampered by geographic restrictions in the selection and appointment of such qualified personnel.

5. Integration of public health and school nursing services in a generalized program, with the training and employment of a sufficient number of additional qualified nurses to meet modern standards.

**Comment (PR-5).**—Since the number of qualified public health nurses is still insufficient to provide even a minimum public health nursing service in the communities of the State, the extension of such services to include school nursing should be deferred until it can be given proper consideration in the development of a well-rounded community health program. The need, however, for the integration of public health and school nursing services was revealed in many of the studies made by the Commission.

6. Increase the effectiveness of the general practitioner by expansion of county laboratory systems—or approval of existing local laboratories for certain purposes—to make readily available such diagnostic facilities to every community and physician in the State.

**Comment (PR-6).**—The practice of modern medicine by the general practitioner and the specialist requires not only that there be adequate diagnostic laboratory facilities available but that there should be no barriers to their use. Several studies made by the Commission, including the study of patients discharged from hospital wards and the study of medical care in welfare districts, revealed that there is a tremendous disparity between the different communities, and even between individual physician and patients—in the extent to which laboratory facilities and procedures are available or are requested and used.

An inventory and appraisal of existing laboratory facilities throughout the State is being made to develop a program which would permit each physician an opportunity to secure at least the basic modern laboratory analyses, in every instance where in his professional judgment they are needed, irrespective of the economic status of the patient. One way of achieving this minimum objective is to expand the scope of services of existing public health laboratories to include the performances of urinalyses, blood counts, blood chemistry and basal metabolism tests, in every instance when requested by a physician.

7. Establishment of a coordinated system of therapeutic and diagnostic tumor and cancer clinics and making available to approved local institutions State or Federal radium, or x-ray equipment, for specific treatment by qualified radiologists.

**Comment (PR-7).**—This recommendation has been carried out by the new Division of Cancer Control established in the State Department of Health upon the basis of the findings of the special Cancer Commission.

8. Promotion of a comprehensive maternity program, to include amendments to the Public Welfare Law and necessary additional legislative appropriations to provide State aid for necessary hospital care of maternity cases in approved institutions.

**Comment (PR-8).**—Considerable progress has been made in the development of a comprehensive maternity program by the successful operation in a number of areas of demonstration projects developed by the State Department of Health with funds made available under the Federal Social Security Act.

9. A reorientation of the rôle of the approved general hospital, public or private, in the preventive and curative services of the community, so that:

a. Unnecessary duplication of accommodations or wasteful competition on a local or regional basis may be eliminated;

b. The general practitioner and his patient may make more effective use of the consultant, specialist and laboratory services and modern therapeutic and diagnostic equipment which should be available in an approved general hospital and out-patient department.

c. The general practitioner may have an increased opportunity to treat cases that fall within his sphere of competence, in the patient's home, in the physician's office, or in the hospital. Also, that the general practitioner may have a better opportunity to enjoy the professional benefits incident to working on a hospital staff with his colleagues.

d. Social service in the hospital may be integrated with community social services to provide more effective methods of communication between the hospital and the general practitioner in the interests of continuity of treatment to promote the patient's restoration to health or the best possible social adjustment in the light of his condition.

**Comment (PR-9).**—The central position of the general hospital in any long range health program, State or local, has been recognized in most of the studies made by this Commission. These studies were designed to reveal the current status and relationship of the general hospital in the practice of medicine in New York State and the rôle which it plays in meeting the health needs of both the individual and the community.

The study of medical care in welfare districts was undertaken to reveal the extent to which care in a general hospital was requested and utilized, both by persons receiving other forms of public assistance and by persons otherwise able to provide for themselves but unable to pay for necessary medical care. The study of medical care programs operated by welfare departments was planned to reveal the interrelationships between the agencies in the community having responsibility for the provision of medical care, including hospitalization, for persons unable to provide it for themselves.

The study of patients discharged from hospital wards in New York State and the study of the payment status of patients receiving care in hospital wards or clinics, was undertaken in the belief that an intimate analysis of the circumstances surrounding the admission and care of individual patients in hospital wards or clinics, including the economic factors, should reveal a graphic picture of the current functions of the general hospital in the distribution of medical care in New York State. These studies were designed also to reveal the various ways by which responsible governmental agencies could use more effectively the hospitals operated by some municipalities and the extensive facilities available in the widely distributed voluntary hospitals in the State.

A general hospital cannot be used effectively unless a trained staff, including competent physicians, is readily available to make the most effective use of its facilities. Another study by the Commission was devoted to the problems of graduate medical education, including intern training, and was devised to reveal hospital staff practices in the voluntary hospitals in upstate New York. These staff practices were considered in the light of the standards adopted by the American College of Surgeons and the American Medical Association in order to appraise both the quantity and the quality of the medical care provided by these hospitals.

Other studies made by the Commission endeavored to define the central position of the general hospital in the existing and proposed plans for the provision of medical care on a voluntary prepayment basis, as well as its relationship to the control of communicable disease, and certain other diseases of public health importance which are now considered to be essential activities of a well-rounded public health program.



10. Immediate revision of the State Insurance Law to permit and encourage sound and well-planned voluntary health and medical care insurance schemes as well as expansion of voluntary hospital service insurance with ample provisions for record-keeping, and current analyses to provide actuarial data directly related to the individual health needs, met by the voluntary insurance schemes, in New York State, as one of the bases for the formulation of a long range health program for the State.

**Comment (PR-10).**—The Commission has continued its discussions and studies of current and proposed plans for the distribution of medical care on a voluntary prepayment basis.

The adoption of Article IX-C of the State Insurance Law was followed by the initiation and development of voluntary medical care insurance schemes in addition to the continued expansion of existing voluntary hospital service plans. The Commission has followed closely the development of such schemes in this State and has made a careful study of similar legislation and trends in other states. While sufficient actuarial data are not yet available for a proper evaluation of the specific plans and trends, there was accumulated evidence sufficient to justify continued emphasis by the Commission on a policy of encouraging the widest possible range of experimentation in this field.

The need for such broad experimentation is posed in the difference in procedures required in plans operating under the medical expense indemnity and medical service principle. The differences in principle lead to variations in the completeness of medical care and scope of preventive services provided.

The need for increased emphasis on the necessity for professional supervision by the appropriate State agencies, of the quality of medical care rendered under such prepayment schemes, was revealed in analyses of existing or proposed plans and legislation in New York and other states.

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The Act<sup>2</sup> creating the Health Commission stated that "the health of the inhabitants of the State is a matter of State concern." This principle was specifically incorporated in the revised Constitution adopted by the vote of the people in 1938. The Commission interpreted this responsibility as embracing not only recommendations for immediate action but charting the next steps to be taken in the development of a long range health program, by directing its efforts toward this objective in an orderly fashion. For these reasons it presented in its Preliminary Report<sup>3</sup> ten specific recommendations for future study. Progress made during the current year in carrying out these recommendations for study is summarized below under each recommendation.

### **Recommendations for Further Study**

1. Thorough study of all aspects of the problem of meeting the demand for compulsory health insurance for wage earners, including their dependents, in fixed income levels.

**Comment (RFS-1).**—The Commission immediately recognized that while compulsory health insurance is one of the methods of distributing medical

<sup>2</sup> Chapter 682, Laws of 1938.

<sup>3</sup> Legislative Document (1939) No. 97.

care, it is primarily a procedure for pooling funds contributed by insured persons and their employers, using such funds to pay for such medical care and to provide cash benefits to the insured during the periods of disability. It was recognized by the Commission that the medical needs of wage earners, including their dependents, in fixed income levels, could be met in many ways which differed, one from the other, both with respect to the scope of medical services provided and the methods by which such services were distributed, supervised and paid for.

Compulsory health insurance, therefore, should be considered in the light of its development in foreign countries, the applicability of such development to New York State, and its relationship to other methods of distributing medical care which might be more appropriate to the conditions prevailing in New York State. Hence, the studies made by the Commission of existing and proposed schemes for public provision of medical care, and studies of voluntary hospital service and medical care insurance programs, should be carefully considered, together with the private practice of medicine, in the evaluation of this study of compulsory health insurance.

Due consideration was given by the Commission to the possible social and economic implications for New York State of a compulsory health insurance scheme. To reveal these implications, estimates were made with respect to the extent of coverage and the probable costs to the insured wage earner, industry and the State government, by a hypothetical application of the provisions of the Compulsory Health Insurance Bill<sup>4</sup> introduced by the Honorable Robert F. Wagner, Jr., in the 1939 session of the New York State Legislature.

2. Studies of the relative merits of existing and proposed schemes for public provision of medical care for persons who are unable to secure such care for themselves—and a classification of such schemes according to their applicability to communities varying widely with regard to:

- a. Population composition and density;
- b. Financial resources;
- c. Existing formal public or private medical and health facilities;
- d. Unmet health needs.

**Comment (RFS-2).**—Studies were undertaken by the Commission to survey existing public medical care administration in counties with different characteristics as to population, financial resources and volume of existing health and medical facilities, in order to determine procedures and policies involved in the provision of good medical care for the indigent and medically indigent. Practically all of the field studies were devoted to those sections of the population believed to have experienced the greatest difficulty in securing good medical care for themselves, and for whom government has assumed the greatest responsibility.

Throughout these studies emphasis was placed upon the availability, adequacy and quality of the medical services provided at public expense, together with the degree to which public medical care programs were integrated with the general health facilities in the community.

3. Study of the need and advisability of amending the Unemployment Insurance Law to provide unemployment insurance benefits for wage earners temporarily incapacitated due to illness, and the evaluation of other actuarially sound statutory and administrative schemes for partial restoration of income, for wage earners temporarily incapacitated by illness. Due consideration

<sup>4</sup> Assembly Bill, Int. No. 2252, Print No. 2726, 1939.

should be given to the arguments for and against combining treatment and invalidity certification as dual functions of a practicing physician.

**Comment (RFS-3).**—The study made by the Commission of problems involved in proposals to provide partial restoration of income for wage earners temporarily incapacitated by illness, revealed serious financial and administrative difficulties. To amend the Unemployment Insurance Law to provide unemployment insurance benefits for wage earners temporarily incapacitated due to illness, or to provide sickness benefits in cash by other statutory provisions, was recognized by the Commission as involving problems similar to those encountered in the administration of proposed compulsory health insurance schemes—with similar implications with respect to increased costs to the insured, industry and the State. This problem was further complicated by the reluctance of the medical profession to recognize the propriety of combining treatment and invalidity certification as dual responsibilities of a practicing physician.

4. Studies of voluntary hospital service and medical care insurance programs and the extent to which, in the light of the amended Constitution of the State of New York, they protect her citizens against the hazards of sickness. Also, an appraisal should be made of the relative significance of commercial health and hospital expense insurance, in relation to non-profit voluntary plans in operation.

**Comment (RFS-4).**—The Commission has conducted a broad study dealing with many aspects of health insurance, both compulsory and voluntary. It has studied the extension of voluntary hospital service plans and the initiation of voluntary non-profit medical care insurance programs, and has weighed the relative significance of these non-profit voluntary plans with the commercial health and hospital expense insurance schemes, which have been available to the public in one form or another for a great many years. Consideration was also given in these studies to the cost of such programs, the degree of health protection furnished by each, and the relation in terms of their availability to the various economic groups of the population.

5. Special studies in the field of mental hygiene, school hygiene and child guidance, to determine the possibility of a coordinated application, in sequence, of the principles of modern preventive and protective science, to the end that an opportunity may be provided for normal development on the basis of the physical and mental equipment found in each child.

**Comment (RFS-5).**—The Commission recognizes the broad implications of any program designed to provide for the normal development of each child on the basis of his physical and mental equipment. Such a program implies a high degree of coordination between functions now exercised by several different State and local agencies, and should be studied further. The problems involved in the fields of mental hygiene, school hygiene and child guidance should be subjects of serious consideration by the interdepartmental councils suggested in Preliminary Recommendation No. 1 above. Neglect of these problems may be one of the causes for the present constant increase in the population of the mental hospitals maintained by the State, which require disproportionate increases in expenditures for their maintenance.

6. Development of a school health program, in accordance with the best modern scientific standards, and its integration in a comprehensive long range health program both for the community and for the individual. Due consideration should be given to the desirability of providing for each child, a continuity of health



supervision to assure prompt medical, surgical and corrective services, when needed—from infancy, through childhood and adolescence to maturity.

**Comment (RFS-6).**—The necessity of a coordination of existing school health services with a long range health program was indicated through several studies made by the Commission. The question posed as to the relative importance of the educational and medical phases of school health examinations was carefully considered. Although from a pedagogical point of view, health examinations are considered part of the educational process, health supervision by way of medical examination with the appropriate medical and surgical corrective services to be rendered if necessary, seemed to be a basic fact to be considered in evaluating a school health program. Studies made by other investigating agencies have revealed that considerable sums of State money are spent to conduct present school health programs varying widely in scope and effectiveness. Due consideration should be given to the health protection provided under these school health programs in proportion to the expenditures therefor.

7. Studies of the need for additional expansion of governmental health and medical care services to meet special health problems such as:

- a. Pneumonia control;
- b. Cancer control;
- c. Syphilis control;
- d. Tuberculosis control—including hospitalization, rehabilitation, and after care;
- e. Dental care and dental hygiene, especially for children;
- f. Drug addiction control, including the provision of a State farm colony for treatment and rehabilitation of addicts;
- g. Physical rehabilitation and social adjustment for permanently handicapped children, as an integral part of the existing State and local program for the care of remediable crippled children; and
- h. Care of chronic illness and infirmity, including adult physical rehabilitation for restoration of earning capacity.

**Comment (RFS-7).**—Each of the special health problems referred to in this recommendation have been subjects of study by the State Department of Health which has responsibility for the administration of these State sponsored programs. Therefore, the Commission to avoid expensive duplication of effort, has not made detailed studies of each individual problem but has considered these problems in their relationships to a number of the broad studies which it has conducted during the current year. While separate progress reports are presented with respect to recent developments in a number of these disease control programs, the factors involved in chronic illness and infirmity have been given special emphasis in the Commission's studies relating to medical care in welfare districts and patients discharged from hospital wards.

8. Studies of the need for diagnostic laboratory, and consultant and specialist services, as well as a modern clinical, diagnostic and therapeutic armamentarium available to all physicians, through public facility, if necessary. In meeting this need, consideration should be given to the full utilization of existing approved general hospitals.

**Comment (RFS-8).**—The extent of the need for diagnostic laboratory, and consultant and specialist services, together with the rôle of general hospitals

in meeting such needs is revealed in a number of major studies made by the Commission. Special consideration was given to the problems involved in the extension of laboratory services.

9. The study of administrative and jurisdictional control by various agencies of State and local government over public health and medical care activities to determine the advisability of consolidation and eradication of overlapping controls, in the interests of efficiency and economy.

**Comment (RFS-9).**—The Commission's studies of medical care in welfare districts, and medical care programs operated by departments of public welfare, as well as related factors involved in the study of patients in hospital wards, required an examination of the various administrative agencies of State and local government assuming responsibility for meeting the demands for public health and medical care. These studies reemphasized the desirability of active interdepartmental councils on State and local levels to coordinate and simplify present methods of public health and medical care administration.

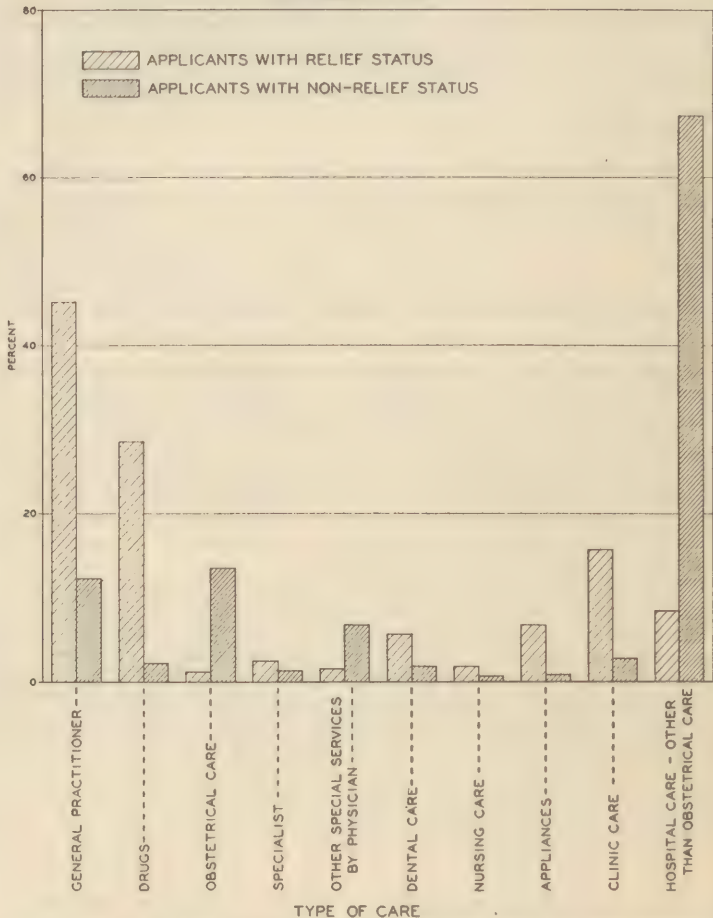
10. Establishment of comprehensive health and medical care administrative facilities on a broad basis—by promotion of county health departments—or by establishment of a county medical administration, as a subdivision of State health and/or welfare districts, or as a part of a decentralized administrative authority, specifically designed to carry out a unified long range preventive and curative health program in the State of New York.

**Comment (RFS-10).**—The deliberations and studies of the Commission and a careful review of the development of the health and medical services in the State during the past twenty-five years indicate the statutory, political and administrative barriers to the establishment of comprehensive health and medical care administrative facilities. Consolidation of existing local administrative facilities requires a new approach with the development of a basic pattern of administration sufficiently flexible to permit adaptation of the details to meet the particular health and medical care needs of the community—without impairment of the full and effective use of qualified medical and health facilities already established.

The study of medical care programs operated by welfare departments has resulted in the development of such a pattern for the use of local counties and cities, the basic requirement of which is medical direction, by a qualified physician, of all efforts to provide necessary preventive and curative services for persons accepted for care at public expense. The value of the integration or consolidation of such a program with a county health administration should be carefully considered in the development of a long range health preventive and curative program for the State of New York.

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CHART I  
 NEW YORK STATE  
 EXCLUSIVE OF NEW YORK CITY  
 COMPARISON OF TYPE OF CARE AUTHORIZED FOR  
 APPLICANTS WITH RELIEF STATUS AND  
 WITH NON-RELIEF STATUS  
 NOVEMBER 1939



REPORTED FOR 40,581 RELIEF AND 1,684 NON-RELIEF APPLICANTS

STUDY OF MEDICAL CARE IN WELFARE DISTRICTS



## HEALTH COMMISSION STUDIES SUMMARIZED

### Study 1

#### MEDICAL CARE IN WELFARE DISTRICTS, NOVEMBER, 1939

##### New York State (Exclusive of New York City)

Any long range State health program which takes into account all of the medical and health needs of each man, woman and child living in the State should have as its foundation the provision of medical care of good quality both for persons receiving other forms of public assistance and for persons otherwise self-supporting, but unable to pay for necessary medical care.

The Public Welfare Law<sup>1</sup> of the State of New York states that "The public welfare district shall be responsible for providing necessary medical care for all persons under its care, and for such persons otherwise able to maintain themselves, who are unable to secure necessary medical care. *The determination as to the medical care necessary for any person shall be made with the advice of a physician.*"<sup>2</sup> Such care may be given in dispensaries, hospitals, the persons's home or other suitable place." The methods by which welfare departments in the State administered the distribution of medical care in the discharge of this responsibility are described in the next study.

The welfare district, as noted above, is primarily concerned with meeting the medical needs of individuals in the lower income groups, including both persons already receiving public relief and persons not receiving such relief but unable to pay for necessary medical care. The kind and volume of requests for medical care to meet the needs existing among this latter group—and the extent to which they are met—is the purpose of this study.

In order to evaluate the requests for medical and hospital care of persons without relief status and the extent to which such requests are met, a study of the upstate welfare departments was undertaken for the month of November, 1939, a month which may be regarded as fairly typical for a study of this nature. Three report forms were prepared and sent to the city and county public welfare officials in the 107 local welfare agencies in the State of New York, exclusive of New York City.

The first general report covered medical care of all types authorized during the month of November, 1939, and was designed to show: the number of authorizations both to persons with relief status and with non-relief status; and, the age distribution of the persons authorized to receive medical or hospital care.

It should be noted that the term "relief status" as used in this study refers to individuals who were recipients of public relief, i.e., home relief (including veteran relief), old age assistance, aid to

<sup>1</sup> Section 83, Article X. <sup>2</sup> Underscored sentence added by Laws 1940, chapter 682, effective April 21, 1940.

dependent children, assistance to the blind, institutional or foster home care, or any form of public relief, with the exception of work relief (WPA).

There was a detailed individual report form to cover each application for medical care, from a person not receiving any form of public relief, pending on November 1, and received during the month of November. This form was designed to show the relief history and economic status of the applicant, the type of medical care involved, and the decision of the public welfare official with respect to authorization of the medical care requested.

Finally, there was a summary report form designed as a control report on the volume of applications for medical care by persons with non-relief status.

In those counties where medical care is administered on a town basis, the county commissioner of public welfare was requested to secure and compile in a single report the desired information regarding the town cases.

Reports were received in time to be included in this study from 78 of the 107 welfare districts in upstate New York. Of this number 75 districts submitted a general report—covering 75 percent of the total number of cases receiving public assistance (home relief, old age assistance, aid to dependent children, and assistance to the blind) in upstate districts during the month of November.

A total of 40,672 persons receiving some form of public relief, and representing 11 percent of the relief population in the districts included in the study, was reported by these districts as authorized to receive medical or hospital care during the month.

Seventy-one, or two-thirds, of the 107 upstate welfare districts, representing 74.2 percent of the total population upstate, submitted data on 2,893 applications for medical or hospital care made by persons without relief status during November, 1939. These applications were either pending at the beginning of the month or received during the month and may be assumed to reflect, for the upstate area, the conditions of persons without relief status, but expressing a need for medical care.

Of the 2,893 applications for medical or hospital care submitted for the month, 59 percent were approved and 18 percent were denied by the departments of public welfare—decision was pending at the end of the month on the remaining 23 percent of the applications. It is interesting to note that of the 512 applications denied, 352, or 69.2 percent, of the applicants were considered, after investigation by the welfare agencies, to be able to pay for their own medical care—309 applicants from their own resources, and the remainder by assistance from legally responsible relatives outside of their own household, or by some other means.

An analysis of the type of care requested by persons without relief status showed that almost 85 percent of the applications were for hospital care alone or for both medical and hospital care. A relatively small number, or 15 percent, were for medical care only. This bears out the observation frequently made, that the illnesses requiring hospital care, which involve greater costs, are

the ones with which families cannot cope, and which force them to apply for care at public expense. In general, the non-hospitalized illnesses involve costs that are comparatively small and which families are better able to meet. Thus families ordinarily self-supporting find it necessary to apply to welfare departments for medical care much less frequently for illnesses not involving hospital care than for illnesses requiring hospitalization.

Comparison of the type of medical care authorized for persons with relief status and for persons without relief status reveals some striking differences. One of the outstanding disparities is evidenced in hospital care which was authorized for 9.1 percent of those with relief status as compared with 79 percent of the group without relief status—this included obstetrical care for 0.7 percent and 11.7 percent of the persons with and without relief status, respectively. In contrast to this are the general practitioners whose services were authorized for 45.1 percent of those on relief as against 12.3 percent of those not on relief.

Other major differences were noted: in authorizations for drugs, amounting to 28.5 percent and 2.1 percent for persons with and without relief status, respectively; and, in authorizations for clinic care, amounting to 15.7 percent as compared with 2.8 percent for persons with and without relief status, respectively.

The services of specialists were seldom requested or authorized for either group—during the month of the study specialists' services were authorized for 2.4 percent of the persons with relief status as compared with 1.3 percent of the persons without relief status.

A comparison of the type of care authorized for applicants with relief status and with non-relief status in November, 1939, is graphically presented in Chart 1, on page 18.

Applications were made for medical or hospital care by or on behalf of persons of all ages, with non-relief status. More than half of the applicants ranged between the ages of 20 and 55 years. In general, there was a noticeable similarity between the age distribution of this group and the group of persons with relief status. However, the relative number of persons, 65 years and over, differed considerably. This age group accounted for 26 percent of the total number of applicants on relief, while it represented only 6 percent of those not receiving any form of public relief. This disparity is not surprising since the relief group is weighted by the comparatively permanent category of old age assistance recipients who are frequently in need of medical care. There was also a substantial difference between these two groups in the persons 20 to 35 years of age. This age group comprised 13 percent of the total number of applicants with relief status in contrast to 30 percent of those with non-relief status.

A graphic comparison of the age of applicants with relief status and with non-relief status is presented in Chart 2—which should be interpreted in the light of the age distribution of the general population, in upstate New York, which is graphically presented in Chart 3. Both the age and the type of care requested by appli-



cants for medical or hospital care with non-relief status is presented in Chart 4. Both the age, and the disposition by departments of public welfare of applications for medical or hospital care, of persons with non-relief status in November, 1939, is presented in Chart 5. Charts 2-5 are on page 25-28.

The hospital was the largest single source of applications to welfare departments for medical or hospital care at public expense for persons not on relief. Of the 2,702 applications for which the source was reported, 1,200 or 44 percent were made by hospitals. The data submitted in this study indicate that it is a common procedure for a person in need of medical care to go first to the hospital, where he is admitted as a patient. The hospital then informs the welfare department of the admission of the patient and his inability to pay his bill, and requests an investigation with a view to acceptance of the bill by the welfare department. The next most common source of application for medical or hospital care was a member of the patient's family or household. This group was responsible for 661, or 25 percent, of the applications. In 18 percent of the applications, the patient himself applied, while in 10 percent of the cases the applications were made in behalf of the patients by physicians.

Of the applications received through hospitals, only 52 percent were approved as against 74 percent of those made by physicians. This may have been due to the fact both, that hospital cases involve greater costs, and that in many instances the hospital did not investigate or could not determine the resources of persons able to pay their own bills—and hence referred them to the welfare department. The source and disposition of all of these applications are summarized in Chart 6, page 29.

The diagnoses of illnesses as reported for applicants without relief status were classified according to 16 standard groupings. Diseases of the digestive system accounted for the largest single number of applications—379 or 14 percent—of which 173 were appendicitis, 53 cholecystitis, and 37 ulcers of the stomach or duodenum. The next most frequent diagnostic groups were puerperal state (337), traumatic conditions and poisonings (330), diseases of the respiratory system (325), infectious diseases (212), and cardio-vascular diseases (161)—comprising 12.6, 12.3, 12.1, 7.9, and 6.0 percent of the cases, respectively. The frequency distribution of 2,676 applicants, for medical or hospital care, with non-relief status by diagnostic groups and disposition of the application by the welfare department is in Chart 7, page 30.

The relief history of 2,644 applicants, for medical or hospital care, without relief status at the time of application, was carefully analyzed. "Relief," as used herein, relates to public relief, excluding work relief (WPA) and may refer to applicants or their families. Almost two-thirds of the applicants who were not on relief at the time of application had been on relief at some time prior to or during 1939, or during both periods. There was a larger proportion of cases previously on relief among the approved group (67 percent) than among those rejected for medical or

hospital care (59 percent). The relief history and the disposition of the request of applicants for medical or hospital care with non-relief status during November, 1939, is in Chart 8, page 31.

The WPA history of applicants, for medical or hospital care, without relief status, was analyzed and is in Chart 9, page 32. WPA may have been interpreted to include work relief programs other than WPA. In more than three-fourths of the cases no member of the household had ever been employed on WPA. In instances where the applicant or some other member of the family had a WPA history, only about half of these were receiving WPA wages at the time of application for medical care. It should be noted that 72.1 percent of the applicants, for whom medical or hospital care was approved, and 85 percent of those for whom it was denied were never employed on WPA projects.

The cash income and other assets of the families of applicants, for medical or hospital care, without relief status were also analyzed.

A comparison of the monthly average cash income of such families during the illness of the applicant and during the year prior to the onset of illness indicates that the monthly average cash income for the group during illness was \$55.82 in comparison with \$62.04 during the year prior to illness. This comparison was made for 1,547 applicants for whom data on cash income were reported. Further evidence of the difference in the economic status of the applicants, for medical or hospital care, in the groups where such care was approved or denied, is the fact that during the period of the present illness the monthly average income for approved applicants was \$53.63 in contrast to \$84.32 reported for those rejected. It should be noted that income as referred to here applies only to cash income and does not include "income in kind," such as free rent, board, fuel, light, milk and farm produce. These items, singly or in various combinations, were reported in a small number of cases either in addition to cash income or where there was no cash income.

Insurance, real estate, bank accounts, and farm and garden produce on hand, were among the assets reported by applicants, for medical or hospital care, without relief status.

Information on insurance was available for 1,865 of 2,893 cases. More than one-third of the 1,865 cases were reported to have insurance ranging in value from less than \$25 to more than \$5,000, of whom 160, or one-fourth of those with insurance, had policies with values in excess of \$1,000. Of the 160 applicants with insurance in excess of \$1,000, 96 were approved for medical or hospital care at public expense and 5 out of 10 applicants with insurance policies in excess of \$4,000 were approved for such care. In a small number of cases, insurance was reported as having no cash or adjustment value while in about 8 percent of the applications the insurance were reported as adjusted or in the process of adjustment. The adjustment of the comparatively expensive "industrial" type of insurance policies to permit conversion to paid-up

life insurance or an inexpensive annual premium whole life policy is in many instances to the advantage of the insured person.

About 5 percent of the applicants had bank accounts, while approximately 6 percent had some farm and garden products on hand. A comparison of the approved and denied groups shows that somewhat higher proportions of those whose applications, for medical care, were denied, were reported to have insurance, real estate and bank accounts.

The size of family for all applicants, for medical or hospital care, with non-relief status, averaged 4.1; while for the approved and denied groups the averages were 4.3 and 3.9, respectively.

Data were submitted for 1,395 of 2,893 total number of applicants with non-relief status, making possible a comparison of the monthly budget to determine eligibility of such applicants for medical or hospital care with the regularly monthly relief budget which would ordinarily be applied to the families of such applicants. For 734 of these 1,395 applicants the monthly budget used to determine eligibility for medical or hospital care was reported to be higher than the regular monthly relief budget used for a family of the same size and composition. This proportion was also true for the applicants approved for medical care, while the denied group had a relatively larger number or 66 percent.

Statistical analyses of applicants for medical or hospital care, without relief status, were also made with respect to the following:

1. Diagnosis of illness classified by type of care requested.
2. Type of care requested and authorized.
3. Monthly average cash income of family in relation to size of family.
4. Monthly budget of family used to determine eligibility for medical care in relation to size of family.
5. Diagnosis classified by source of diagnosis.
6. Type of care requested classified by reason for denial.
7. Ability of family to pay for medical care.
8. Person responsible for consideration of application for medical care.

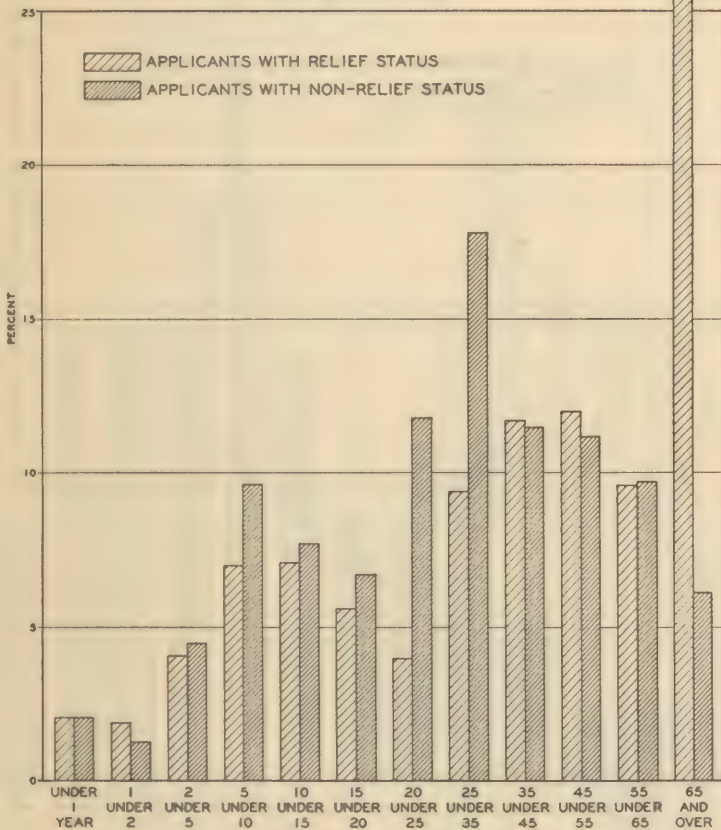
(NOTE: Charts 2-9, referred to in Study 1, appear on pages 25-32.



CHART 2  
NEW YORK STATE  
EXCLUSIVE OF NEW YORK CITY

COMPARISON OF AGE DISTRIBUTION OF  
APPLICANTS WITH RELIEF STATUS AND APPLICANTS  
WITH NON-RELIEF STATUS, AUTHORIZED  
TO RECEIVE MEDICAL OR HOSPITAL CARE

NOVEMBER 1939



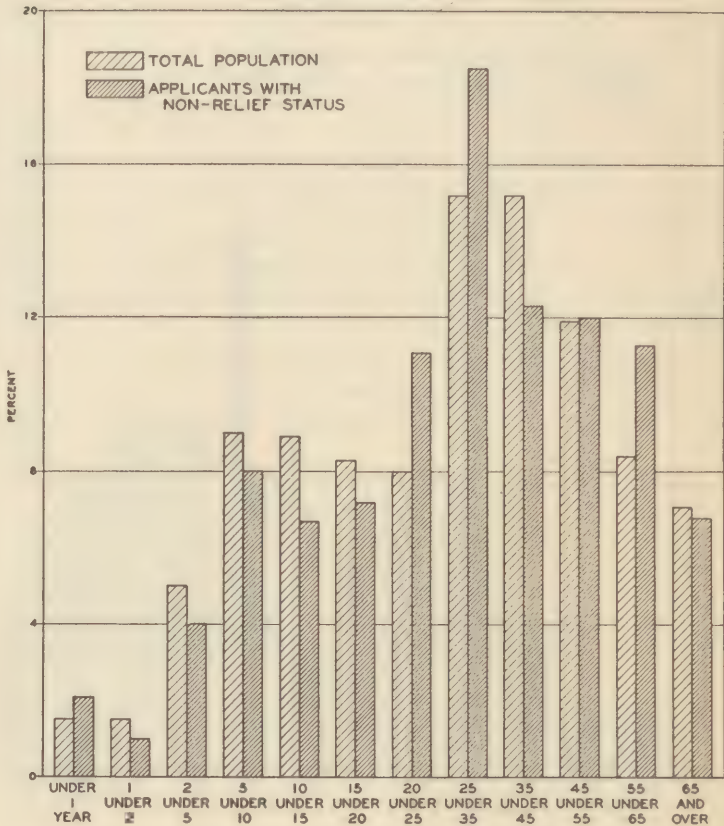
REPORTED FOR 38,494 RELIEF AND 1,698 NON-RELIEF APPLICANTS

STUDY OF MEDICAL CARE IN WELFARE DISTRICTS

CHART 3  
NEW YORK STATE  
EXCLUSIVE OF NEW YORK CITY

AGE DISTRIBUTION OF TOTAL POPULATION\*  
AND APPLICANTS FOR MEDICAL OR HOSPITAL CARE  
WITH NON-RELIEF STATUS

NOVEMBER 1939



REPORTED FOR 2,793 APPLICANTS

\*5,657,620: U. S. CENSUS OF 1930

CHART 4

NEW YORK STATE  
EXCLUSIVE OF NEW YORK CITY

AGE AND TYPE OF CARE REQUESTED  
APPLICANTS FOR MEDICAL OR HOSPITAL CARE  
WITH NON-RELIEF STATUS

NOVEMBER 1939



REPORTED FOR 2,612 APPLICANTS

STUDY OF MEDICAL CARE IN WELFARE DISTRICTS

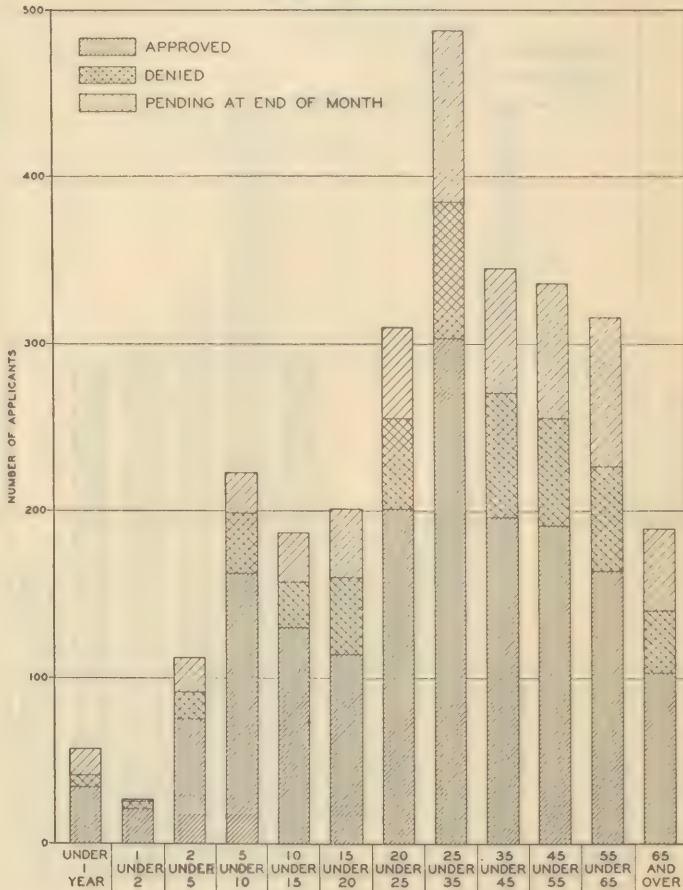


CHART 5

NEW YORK STATE  
EXCLUSIVE OF NEW YORK CITY

AGE AND DISPOSITION  
APPLICANTS FOR MEDICAL OR HOSPITAL CARE  
WITH NON-RELIEF STATUS

NOVEMBER 1939



REPORTED FOR 2,793 APPLICANTS

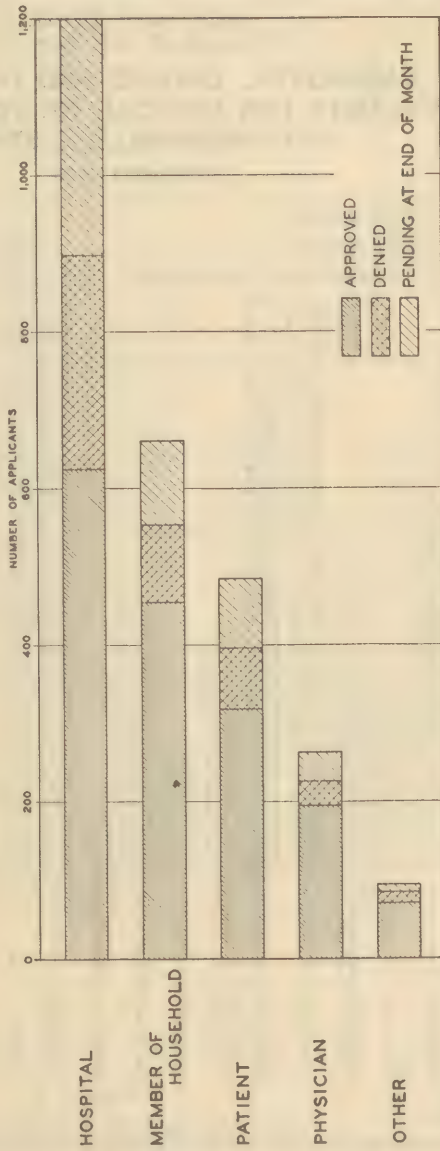
STUDY OF MEDICAL CARE IN WELFARE DISTRICTS

CHART 6

NEW YORK STATE  
EXCLUSIVE OF NEW YORK CITY

# SOURCE AND DISPOSITION APPLICANTS FOR MEDICAL OR HOSPITAL CARE WITH NON-RELIEF STATUS

NOVEMBER 1939



REPORTED FOR 2,702 APPLICANTS

STUDY OF MEDICAL CARE IN WELFARE DISTRICTS

CHART 7  
 NEW YORK STATE  
 EXCLUSIVE OF NEW YORK CITY  
 DIAGNOSTIC GROUPS AND DISPOSITION  
 APPLICANTS FOR MEDICAL OR HOSPITAL CARE  
 WITH NON-RELIEF STATUS  
 NOVEMBER 1939

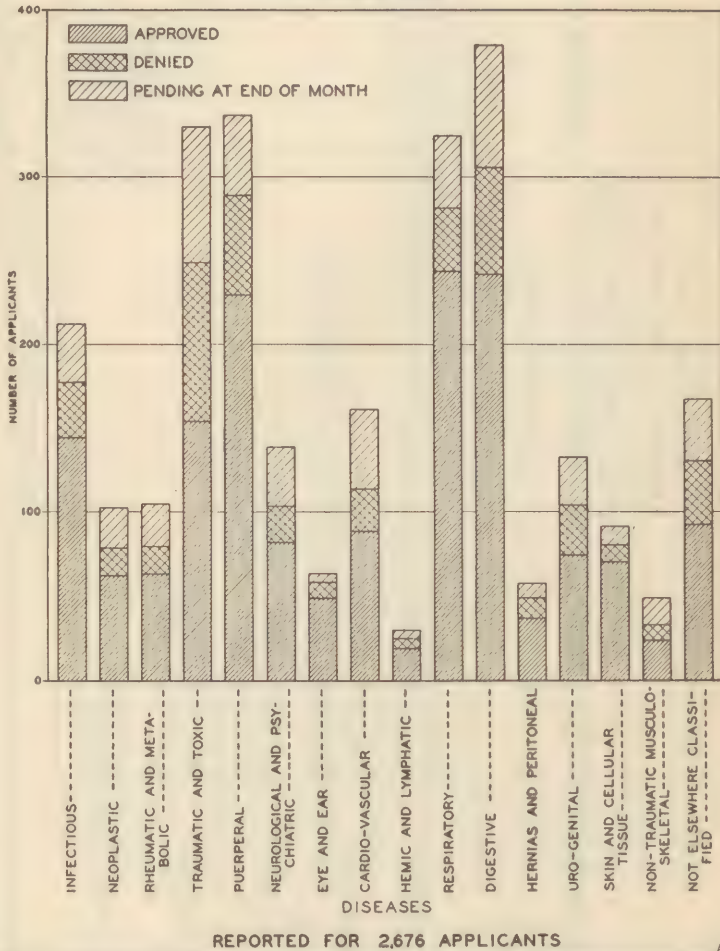


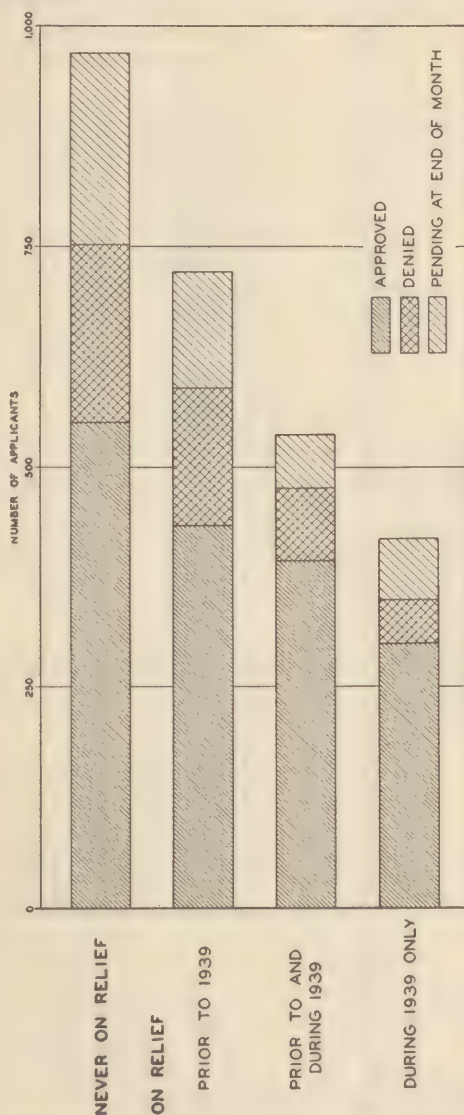


CHART 8

NEW YORK STATE  
EXCLUSIVE OF NEW YORK CITY

# RELIEF HISTORY\* APPLICANTS FOR MEDICAL OR HOSPITAL CARE WITH NON-RELIEF STATUS

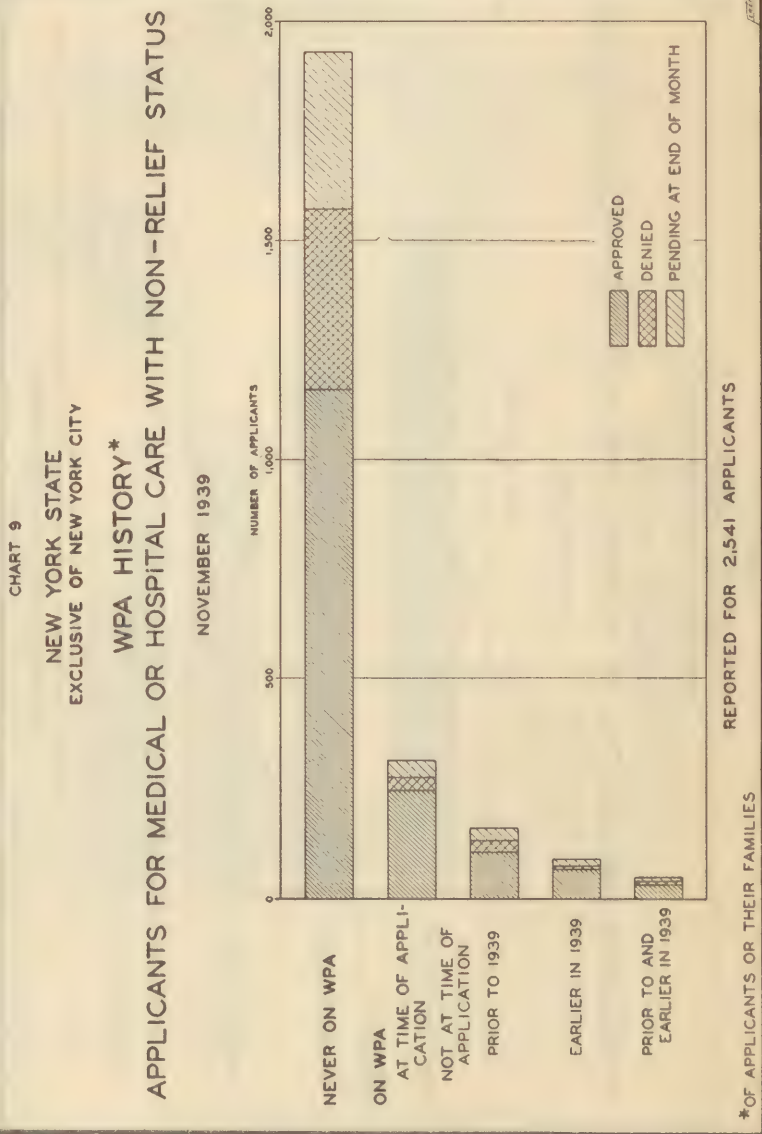
NOVEMBER 1939



REPORTED FOR 2,644 APPLICANTS

\*OF APPLICANTS OR THEIR FAMILIES

STUDY OF MEDICAL CARE IN WELFARE DISTRICTS



## Study 2

### MEDICAL CARE PROGRAMS OPERATED BY DEPARTMENTS OF PUBLIC WELFARE, 1939

#### New York State (exclusive of New York City)

The increasing demand for medical care for persons unable to provide it for themselves requires careful consideration of the existing public programs for the distribution of medical care. Provision of medical care for the needy has been traditionally an expression of neighborly helpfulness. As a larger proportion of people in the community have become unable to provide care for themselves, organized medical charities, both public and private, have supplemented the assistance given by the individual.

In New York State, public responsibility for medical care of the needy is carried partly by local welfare departments as an integral part of the relief program, partly by health departments and partly by hospitals maintained at public expense. In New York City, the major part of the medical care program is carried by the Hospitals Department which operates an extensive system of city hospitals and clinics, with the Welfare Department responsible for medical care in the home for persons to whom it is granting relief. In the territory outside of New York City, responsibility usually rests on the local welfare departments though in a few cities, the health department provides physician's services in the home and in some clinics.

In order to understand the organization of medical care programs operated by departments of public welfare, it is necessary to review the local administrative structure. Under State statutes, relief is now administered and financed by three units of local government—the town, the city and the county. The State has power of supervision over all forms of relief administered by local agencies to meet the varied requirements of the needy—these types of relief include home relief, veterans' relief, old age assistance, aid to dependent children, assistance to the blind, care of children in institutions and boarding homes, hospital care, and institutional care for adults in public homes or private institutions. The State reimburses the localities for part of the cost of the first types of relief listed above. The Federal Government provides, through the use of Social Security funds, a part of the cost of old age assistance, aid to dependent children, and assistance to the blind. Medical care is an essential part of each of these types of relief.

While there has been no decrease in the legal responsibility of the localities for the administration of relief through various local agencies, the system of State aid for relief has given the State definite responsibilities for determining the quality and methods of local administration, particularly of those types of relief to which the State contributes.

The Public Welfare Law of 1929 under which the State now operates, changed the whole concept of public relief and care.



Whereas the Poor Law had emphasized almshouse care as the basic form of relief, the Public Welfare Law made home relief the fundamental method, with other types of care authorized when needed. It also established public responsibility for provision of medical care for "persons otherwise able to maintain themselves who are unable to secure necessary medical care," i.e., the so-called "medically indigent."

For the purpose of local administration of public relief, the State is divided into 57 county public welfare districts and six city public welfare districts which have the same powers as a county district. The administrative head of each public welfare district is known as the commissioner of public welfare. Forty-six cities which form part of a county public welfare district, appoint city public welfare officials, and in each of the 811 towns which administer relief, the town board appoints a public welfare officer or authorizes the supervisor of the town to act in this capacity. In 49 of the 57 county public welfare districts, responsibility for the administration and cost of relief is divided between the county public welfare district as a whole, and the towns and the city or cities located in the district. In the other eight county districts town responsibilities have been transferred to the county.

Necessary medical care "may be given in dispensaries, hospitals, person's home or other suitable place."<sup>1</sup> Medical care in the home (and office) is included in the definition of home relief, for which State aid of 40 percent is payable for expenditures made in accordance with the regulations specified in the Manual of Medical Care of the State Department of Social Welfare. Hospital care may be provided in a public hospital or a private hospital inspected and certified by the State Board of Social Welfare—and is a local expense, except for State reimbursement of 100 percent for hospital care provided for "State charges" and of 75 percent for temporary medical or surgical care in a hospital for persons receiving old age assistance and assistance to the blind.

Medical care of varying types is provided to the indigent and medically indigent by the local department of public welfare listed above. The town welfare officer administers, subject to supervision by the county commissioner, medical care in the home or at a physician's office for persons residing and having settlement in the town. All city departments provide medical care in the home and hospitalization for the home relief recipients and medically indigent persons and six city public welfare districts provide also for old age assistance recipients. A few cities are responsible for all forms of relief and therefore for medical and hospital care for all persons residing in their territory. The county department administers all forms of relief which are not provided by the cities and towns within the county public welfare districts, including hospital care for town residents.

The system for administration of medical care is very complex, as it is provided for recipients of each form of relief and responsibility for administration of the various forms of relief is divided

<sup>1</sup> Section 83, Article X, Public Welfare Law, quoted in full on p. 19.

between three units of government. In some cities, for example, medical care is provided by the city department of public welfare, by the county department of public welfare, and by the county board of child welfare, depending upon the form of relief which the needy person is receiving or upon his settlement status. With such a complicated administrative system, it is inevitable that there should be great variations in policies and procedures. Medical care is usually easily available to persons receiving other forms of relief. Greatest variation appears in the granting of medical care for the medically indigent. The present public welfare medical program insofar as medically indigent cases are concerned, operates far more effectively for provision of hospital care than for provision of medical services which might prevent serious illness requiring hospitalization. (See Chart 1, on p. 18.)

In administering public medical care, the welfare official who is not himself trained in medicine, must make use of the medical resources which he finds in his community. He uses the services of physicians, dentists, nurses, pharmacists and related personnel, hospitals, nursing homes, clinics and laboratories. He must provide for the distribution of drugs, medical supplies and prosthetic appliances. A variety of methods are used by welfare departments to secure and pay for medical services. To provide the services of a physician, one or more of the following methods are commonly used:

1. Employment of physicians on a fee-for-service basis, either giving the patient free choice of physician or limiting the choice to a selected panel of physicians.

2. Use of public or private clinics.

3. Employment of salaried staff physicians to treat patients in their offices and in the patient's home with specialists on a fee-for-service basis.

4. Employment of salaried staff physicians to treat patients in the patient's home, or in a clinic.

5. Use of salaried physicians employed by a city department of health for services in the home or in clinics, with or without supplementation of this service by employment of general physicians and specialists on a fee-for-service basis when needed.

6. By any combination of the above methods.

It is not unusual for a welfare department to use different methods to provide medical service for recipients of relief in the different categories. For example, recipients of home relief may be treated by staff physicians, while recipients of old age assistance and obstetrical or other cases may be given service on a fee basis. It is customary to provide medical care for inmates of county homes by salaried physicians, though the county departments seldom provide medical care by salaried physicians for any other type of relief.

The method of providing hospital care depends upon the facilities in each community. A few localities maintain a public hospital

which provides care for welfare patients. In the absence of a public hospital, welfare departments provide care in voluntary hospitals through a per diem payment. Welfare departments usually have agreements with hospitals as to the per diem rate to be paid and the extent to which extras such as fees for the use of operating room, anesthesia, drugs, x-rays, laboratory service, etc. will be paid. In hospitals having no staff or in proprietary hospitals the welfare department sometimes pays fees to physicians and surgeons attending public welfare patients.

It has been estimated that the cost of medical care given by local welfare departments (exclusive of New York City) on which State reimbursement was paid for the year ending June 30, 1939, amounted to approximately \$3,000,000. The category of home relief accounted for \$1,644,403 of this amount. Old age recipients accounted for \$496,385 for hospital care and \$824,039 for home care. The other relief categories accounted for the balance. Public expenditures for general hospital care outside of New York City for the calendar year 1939 amounted to \$10,336,000.

The expenditures for home medical care have markedly increased during the past decade. Outside of New York City in June, 1932, the expenditures for medical care in the home were \$25,000 which in 1939 rose to approximately \$200,000 as the average monthly expenditure.

There is a great variation in the administrative methods and procedures for distribution of medical care to the needy in the public welfare departments. Local plans have been markedly expanded and new ones are steadily being instituted. In the larger unit there is a trend toward the employment of a physician in the capacity of director or consultant in order to secure better administrative control and through professional supervision, improve the quality of medical care. In the majority of the departments, however, there is a distinct lack of centralization and responsible administrative direction in the medical program.

The Commission has reviewed current surveys of medical care programs operated by local departments of public welfare. These surveys were made by the medical and medical social work staff of the State Department of Social Welfare.

While no two programs among those of the 108 welfare districts are strictly comparable, a review of a representative sample of these public medical care programs reveals the following variations in policies and procedures.

Although in all of the welfare districts under study there existed organized administrative programs for the distribution of medical care to public relief recipients, in many instances the lack of understanding of the relationship between medical and social problems prevented effective use of all the existing facilities.

In some of the districts studied the social service and the medical care programs functioned independently of one another. In many instances personnel of the local social service division were unfamiliar with the medical problems of their clients and the local medical care facilities. The social case records rarely included



data on health problems or medical services. Social planning was deficient in respect to medical social case work designed to effect social and medical rehabilitation.

The programs studied showed a lack of centralization or responsible administrative direction. In most instances the local distribution of medical care to the several relief categories had separate and uncoordinated administrative mechanisms. Many methods of authorizing medical care were in force. In some instances the authorization was practically automatic whereas in others the use of medical facilities was frequently discouraged in order to reduce tax expenditures. When a lay welfare officer did attempt to differentiate between applicants on the basis of medical need he either acted on the basis of his inadequate grasp of medical problems or he found it necessary to seek the advice of a physician. Study of medical care plans in operation gave clear evidence of the need for medical direction and supervision. For the sake of efficiency and economy professional medical judgment should be brought to bear on the problems of providing appropriate preventive and curative medical care for the needy.

It was found that welfare officers were usually aware of the total costs of their medical care programs but did not have readily available data on costs for various items, individual clients or types of illness. Such data are essential in future planning and administration of public medical care programs.

Another weakness of the present program is the lack of coordination of the various medical and public health programs, public and private. While the welfare departments necessarily have developed working relationships with the voluntary hospitals, it was frequently found that there was little relationship between the welfare department and the health department. Further integration of the welfare medical program and the public health program is essential to secure maximum results from present public expenditures in these fields.

Under the present public medical care program, medical care as a rule is available to persons receiving relief. The scope of the Commission's study of these programs does not permit any evaluation of the adequacy of this medical care from the viewpoint of quality. Such medical care for the medically indigent group not on relief is far from satisfactory. A considerable amount of hospital care is provided though the extent to which the public welfare authorities have accepted responsibility for payment of hospital care for this group varies greatly. Relatively little home medical care is provided for this group by the welfare departments.

In New York City, the requirements of the Public Welfare Law in relation to the provisions of all types of medical care for the non-relief case is ignored. The New York City Department of Public Welfare provides medical care in the patient's home only for persons to whom it grants relief, and there is no public provision whatsoever for this type of care for persons not on relief. The medically indigent group in New York City have available extensive public and private clinic services, but if they are unable to pay for

the services of a physician in their home they must depend upon the charity of a private physician or call an ambulance from one of the hospitals.

While the welfare departments in the rest of the State recognize their responsibility under the Public Welfare Law for provision of home medical care as well as hospital care for persons not receiving relief, the fact remains that relatively little home medical care service is provided for this group by the welfare departments. The Commission's study of medical care received by ward patients prior to admission to the hospital indicates that the medical needs of this group are not being well met and that serious consideration should be given in order to make more readily available home medical care for the medically indigent not on relief.

Further study is obviously needed of the policies and practices of the welfare departments in administration of the medical program for persons not on relief. The great variation in the economic standards used to determine eligibility, both for home medical care and hospital care, must be corrected and ambulatory care must be made more readily available, if the present public medical care program is to operate effectively in meeting the medical needs of this large group of the population.

Leaders in both the health and welfare fields have recognized the need for integration of health and welfare efforts. The following clear statement by Paul V. McNutt, Federal Security Administrator, expresses this viewpoint:

"In planning for health security, we must build on what we have, utilizing all existing facilities capable of rendering effective medical and health service. Sound planning and good administration are basic to any aspect of the welfare program. Without these, effective service is impossible. Along the road ahead where public-welfare agencies and public-health departments must meet in a coordinated approach to the expansion of public services in a community, it is especially necessary that no superfluous administrative machinery be set up."

**The following policies and procedures are recommended by the Commission as basic to efficient operation of public medical care programs by local welfare departments:**

1. Greater centralization and integration of the administration of medical care to all categories of relief.
2. Professional medical direction of the medical program in order that medical judgment may be brought to bear on the problems of providing appropriate preventive and curative care for relief recipients and the medically needy and of keeping expenditures at the lowest cost consistent with quality and efficiency.
3. Effective working agreements between the welfare departments, medical care and public health agencies in the community in order to effect a full utilization of existing facilities and elimination of expensive duplication.

4. Better coordination of medical care and social service functions in the welfare departments, to insure the complete individualization of each patient's medical rehabilitation within the limitations of his disease or infirmity.

5. Accurate recording of data concerning not only the total cost of the medical care program but also the costs for various items, individual clients and types of illness.

6. Adoption of policies which would make more fully effective the provisions of the Public Welfare Law in relation to the provision of medical and hospital care to those otherwise able to maintain themselves who are unable to secure necessary medical care.

If medical care of good quality is to be made available at public expense for persons not able to provide such care for themselves, the advice of a duly licensed physician is essential in the determination as to the medical care necessary. This fact became so obvious during the course of the deliberations of the Commission with other interested agencies that a bill was introduced in the legislature at the request of the Commission, to incorporate this concept into Sections 83 and 85 of the Public Welfare Law.<sup>2</sup> This bill, with the signature of the Governor, became chapter 682 of the Laws of 1940, effective April 21, 1940.

<sup>2</sup> See p. 19 for full text of amended Section 83 of the Public Welfare Law.

### Study 3

## STUDY OF PATIENTS DISCHARGED FROM HOSPITAL WARDS, 1939

### New York State (Exclusive of New York City)

This study is based on an analysis of the hospital and welfare records of 2,099 patients discharged from the wards of 11 representative hospitals in New York State, exclusive of New York City, during 1939, together with an analysis of the interviews obtained through personal visits to 771 of these patients.

The Commission in its preliminary report<sup>1</sup> to the Legislature submitted May 15, 1939, included the following among its recommendations for further study: "Study of the need for diagnostic laboratory and consultant and specialist services, as well as a modern clinical, diagnostic and therapeutic armamentarium available to all physicians, through public facility, if necessary. *In meeting this need, consideration should be given to the full utilization of existing approved general hospitals.*" A study along these lines should take into account, not only the quantity of medical care, but also its quality. This study was planned to obtain an insight into problems of medical care in communities of vari-

<sup>1</sup> Legislative Document (1939) No. 97.



ous types, served by a variety of general hospitals. It was hoped that the data from such a study would aid in planning a long range health program.

It was decided to select for study a group of persons known to have been seriously ill. Histories of serious illness should shed light on the factors involved in securing medical aid. To study the course and effect of severe illnesses, records of individuals with a recent illness experience in a hospital were used. Specific diagnosis are usually recorded for persons who have been hospitalized. By reviewing records of persons already discharged from the hospitals we can make sure that the progress of disease at a certain point has been evaluated by persons competent to make medical judgments. Both medical and economic data are studied to determine the type and effectiveness of the medical care provided.

There is a group of persons in every community who cannot bear the extra burden of severe illness. These people are otherwise able to maintain themselves, but cannot pay for necessary medical care. Persons already receiving other forms of relief are of course even more dependent upon public funds when illness strikes.

It was decided to study patients discharged from hospital wards, since these two groups make up a large proportion of the admissions. The fact that an individual has had a hospital experience provides a focus in his medical history from which it is possible to trace factors relating to the availability and adequacy of the medical service he gets, together with the economic problems involved.

To obtain a fair sample, studies were made of records of ward patients in different types of hospitals serving rural, suburban and urban communities—together with the degree of community organization to meet health and welfare needs in these communities. This community organization included the presence of full-time or part-time health officers, presence or absence of organized clinics, and the extent to which welfare activities were centralized in the county department or were served by county and town welfare officials working independently.

Since hospital staff organization and the accessibility of hospital facilities, including diagnostic and curative services, are reflected in the activities of each medical practitioner in the hospital area and may greatly influence the type of medical care which each individual medical patient receives, the 11 general hospitals studied were analyzed both with respect to the type of control, public or private, and, in communities they serve, the extent to which they meet the standard ratio of 4.5 hospital beds per thousand of population.

A hospital, in order to fulfill its purpose, must be readily accessible to the population it serves both in respect to geographic location and ease of gaining admission.

Ward cases at each hospital were selected in reverse order of discharge, the series beginning with the most recently discharged

patient. Since the rate of patient discharge varied from hospital to hospital, the earliest discharges from the various hospitals fell on different dates. However, in the series of samples studied, which ranged from 80 to 600 ward patients, no discharge occurred prior to February 1939. The size of the samples selected from each hospital was decided on the basis of the population of the area served and the total admissions to the hospital.

A graduate nurse with training and experience as a hospital inspector, was employed to secure data from hospital and welfare department records. The primary emphasis in the study of medical records was on the history of each patient's disease in terms not only of medical sequence but also of individual and family welfare. No attempt was made to evaluate the quality of hospital care. The illness which led to hospitalization was considered the major subject of study. Information was collected relating both to the type of illness of each patient and its duration and severity—and also the stage of disease when medical care was first given, who gave the care, the results of the diagnostic and curative measures provided, and the method of payment for the care given. In addition to data relating to physical examinations and the use of laboratory procedures, used as evidence of the extent to which modern diagnostic methods were used, inquiry was made concerning the use of home remedies for the extent to which the use of preventive measures would have mitigated the disease process and lightened the economic burden. When delay occurred in securing prompt medical attention, an attempt was made to determine whether the reason was deficiency in medical facilities, inability to pay for medical care, lack of appreciation of the need for medical care, or sheer neglect.

In order to obtain a fair basis for interpreting data relating to medical care, inquiry was made into the economic background of the family. The relief history was considered part of the essential data, since serious illness may be the cause of indigency or vice versa.

The information collected from the hospital and welfare records was supplemented by information secured by public health nurses, by visits to the homes of patients. In these visits an inquiry was made with regard to their medical experience before and after the hospitalization and the economic background of the family.

Form 1 was designed to record the information for patients discharged from hospital wards—from hospital and welfare department records—and the 2,099 completed schedules were statistically analyzed by a statistician on the staff of the Commission, aided by personnel and punch card equipment made available by the State Departments of Health and Social Welfare.

Form 2 was designed to tabulate data compiled by the public health nurse investigators at the time of the field interviews with patients or responsible members of their families. Information of this type was secured in time for inclusion in this study for 771 of the 2,099 patients for whom information was secured on Form 1. Hence the tabulations of Form 2 information is provisional only,

and complete analyses of all available data will be presented in a future report of the Commission.

The data secured on Form 1 from an analysis of the hospital and welfare records of 2,099 patients discharged from the wards of 11 representative hospitals in upstate New York during 1939 included for each patient hospital, age, sex, color, marital status, occupational group, length of stay in hospital, discharge diagnosis, where the surgery was performed, survival, physician who treated patient in hospital, and agency responsible for hospital (including method of payment when patient was responsible).

The age distribution of these patients combined for all hospitals showed no unusual features and should be compared with Charts 2 and 3 presented above in the Summary of Study 1. The maximum frequency was reached in the age group 25 to 35 which accounted for 17 percent of all cases. Almost half of the 365 patients in this age group were hospitalized for puerperal conditions. Beyond age 35, the numbers hospitalized in each successive 10-year group decreased until the group aged 65 years and over—which, although numerically fewer in the community, contributed disproportionately to this hospital population.

The sex distribution of the patients revealed an excess of females over males in a ratio of about 3 to 2, with this ratio even higher in the rural hospitals studied since a large portion of the ward care in these hospitals was for obstetrical conditions.

The occupational distribution of patients revealed the same trend with the housewife group accounting for 722 individuals or almost a third of the total studied and about 60 percent of the entire group of female patients. This observation is further supported by the discharge diagnoses among which the puerperal state accounted for 390 of the 2,099 cases.

The length of stay in the hospital, when analyzed, shows that the mean (average) length of hospital stay was about 16 days and the median (middle) length of stay was 10.6 days, for the 2,093 cases for whom the length of stay in the hospital was reported. For a more detailed analysis of length of stay see Charts 10 and 12, pages 47 and 49.

In order to indicate the influence that ability to pay for hospitalization may have had on the length of hospital stay, the periods of hospitalization were analyzed separately by patient and public welfare responsibility for payment of the hospital bill. The mean and median lengths of stay, respectively, of patients for whom a public welfare agency assumed responsibility for hospital bills was 20.4 days and 12.6 days in contrast to 9.5 days and 8.2 days when the patient's family was responsible.

The discharge diagnoses, copied from the hospital records, were coded by a physician using a modification of the Welfare Council "Classified List of Diagnoses for Hospital Morbidity Reporting."<sup>2</sup>

<sup>2</sup> Published May 1939, Research Bureau of the Welfare Council of New York City, based on the "Standard Classified Nomenclature of Disease" by H. B. Logie, The Commonwealth Fund, 1933.



The main groups of this short list of 90 titles are in general based on anatomical considerations, with the exception that general infections, neoplasms, and rheumatic, metabolic, and traumatic conditions are given precedence.

The diagnoses of the greatest number of patients referred to the puerperal state, and, as stated above, accounted for 390 of the 2,099 cases. Diseases of the digestive system accounted for 353 of the cases; of these 188 were diagnosed appendicitis. Diseases of the respiratory system comprised 339 cases, of which 193 were infectious hypertrophy of the tonsils or adenoids. There were also 123 cases of neoplasm and 97 cardio-vascular cases. These data are shown in Chart 11, page 48, and should be compared with the findings of the first study as revealed in Chart 7, page 30.

Economic conditions in relation to diagnosis are revealed in the observation that hospital bills for illnesses which were of a prolonged nature were assumed as a responsibility by public welfare officials in a higher proportion than diseases of shorter duration. For example, welfare departments assumed hospitalization costs for: 25 of the 35 cases of tuberculosis of the respiratory system; and, 71 of the 123 patients with neoplastic diseases. On the other hand, only 143 out of 390 puerperal cases and 56 out of 142 cases of acute appendicitis—were accepted as public charges for the cost of their hospitalization.

The surgical rate in this study was 40 percent of all the patients, and the obstetrical rate was 17 percent. Although surgical cases made up 40 percent of the entire group of cases, only 13 percent of the 168 hospital deaths recorded in the study occurred among surgical cases. The greatest number of deaths occurred in the cardio-vascular disease group.

The responsibility for payment of hospital charges revealed that 833 or 40 percent of the 2,099 patients were expected to pay for their own hospital care—and less than half of these paid their hospital bills in cash. Fifty percent, or 1,055 patients, were referred to public welfare officials for hospitalization at public expense. In comparison with the percentage (40) for all patients, a slightly higher proportion of surgical patients (46 percent) and obstetrical patients (57 percent) were expected to meet the costs of their hospitalization from their own resources. In general, the hospitals in the rural areas had a relatively high proportion of patients expected to assume responsibility for hospital charges.

All of the data relating to responsibility for payment of hospital charges are graphically presented in Chart 12, page 49, which should be compared with Chart 1, page 18.

The data secured on Form 2 was filled out by the public health nurse investigators for 771 patients at the time of the home interviews with patients or responsible members of their families, and were analyzed and tabulated to cover the following items: medical care, intervals between first symptoms of illness leading to hospitalization, first medical attention and hospital admission, time between hospital application and hospital admission; scene of first medical visit and reason for delay (if any) in securing medical care; self medication; physician's services prior to illness which

led to hospitalization; physician's services in present illness and payment therefor; clinic services prior to hospitalization for this illness; person or agency responsible for hospital care expense; follow-up services after hospital discharge; and the economic history—including individual and family group annual cash incomes.

A study of the intervals having a bearing on the medical care of patients discharged from hospital wards in relation to the illnesses for which they were hospitalized, is summarized in Chart 13, page 50, and revealed in the instances where specific information was available that:

In 22 percent of the cases medical care was provided within 24 hours of the first symptom of the illness and that more than two-fifths of the cases were admitted to the hospital within the same period—at the other extreme, a group of 42 patients waited more than five years after first observing symptoms before receiving medical attention.

In 80 percent of the cases patients were admitted to the hospital ward within 24 hours of application for admission. Few of the delays indicated difficulty in securing admission to the hospitals since, in some instances, patients preferred to make hospital arrangements in advance for obstetrical care and surgery. In no instance was there evidence that an emergency case was delayed in being admitted to the hospital.

Forty-five percent of the patients reporting indicated that they received their first medical attention in a physician's office for illness which led to hospitalization, and 31 percent received their first medical attention at home. Only 17 percent of the patients received their first medical attention from a physician in the clinic.

More than half of the patients reported that there was a delay in securing medical care—of these, more than half stated that they had not realized the need for medical care, and a third gave inability to pay as one of the reasons for the delay. In only three instances did patients state that the delay in securing medical attention was due to refusal of public welfare officials to authorize care at public expense. With respect to self-medication, more than one-fourth of the patients interviewed admitted this practice, of whom the majority accepted the advice in this respect of a member of the family.

Forty-one percent of the patients interviewed stated that they had never had a physical examination prior to the illness which led to hospitalization—and only a third of the patients reporting a physical examination (representing 20 percent of all the patients) had an examination which included the minimum requirements of physical inspection of all parts of the body with clothes removed, use of stethoscope, and recording of blood pressure.

Fifty-three percent of the physical examinations reported included at least one laboratory procedure—43 percent of these examinations were performed at clinics (including school clinics) and 33 percent were performed at physicians' offices.

Care by private physicians during this illness and prior to hospitalization was reported by 80 percent of the patients (obstetri-

cal patients excluded) of whom about two-thirds had been under care for less than a month. Consultants were called by private physicians prior to hospitalization in only 54 cases. Responsibility for payment for physicians' services for this illness and prior to hospitalization was stated to be assumed by 73 percent of the 585 patients cared for by private physicians. Physicians were known to have extended credit to 332 of the patients assuming full responsibility for payment. (Free care by physicians was reported in only 16 cases.)

Medical or nursing care following hospital discharge was reported by three-fourths of the 745 patients interviewed. However, nursing services were received by only 9 percent of all surviving patients receiving care following hospital discharge. Private physicians attended 333 patients and clinic services were given to 188 patients after leaving the hospital.

Family cash income information was obtained for 645 of the 771 patients interviewed and analysis of these reports revealed that: public relief was the only form of income for 11.5 percent of the families; no cash income whatsoever was reported for 2.6 percent; and only 36 percent of these families received \$1,000 or more per year from all sources combined.

A report on the ante-partum care for the 141 obstetrical cases in the study revealed that eight received no medical attention prior to hospitalization and that of the 133 patients who received ante-partum care, 60 percent were attended by private physicians and the rest received care in clinics. Almost half of the obstetrical patients received some medical attention within the first five months of pregnancy—but three patients received their first medical attention within 24 hours of hospitalization.

Only five of the 137 pregnancies terminating in delivery in the hospital were terminated earlier than the ninth month of pregnancy. There was only one instance in which the patient was delivered before reaching the hospital and in this case a physician was in attendance.

A physical examination by a private physician during the pregnancy was reported by 90 percent of the patients, although less than half of the patients examined reported that such examination included a vaginal examination, blood pressure, urinalysis, and a blood test for syphilis. A blood pressure reading was the most common of these procedures and the vaginal examination the least common.

Provisional analysis of data obtained from health and welfare records of 2,099 patients discharged from the wards of 11 hospitals and 10 representative communities in New York State, and interviews by public health nurses, with 771 of these patients reveals the following:

The proportion of female to male patients was three to two in all the hospitals studied—with this ratio higher in the rural hospital wards, possibly due to the fact that conditions of the puerperal state, numerically, made up the largest diagnostic group of the patients studied.



Diseases of the digestive system, appendicitis predominating, formed the second largest group; diseases of the respiratory system ran third, with hypertrophy of the tonsils comprising the majority of these cases.

Hospital ward patients for whom public welfare agencies assumed financial responsibility were more frequently suffering from diseases with a long course, such as neoplasms and tuberculosis, and tended to remain in the hospitals for longer periods than patients expected to pay their own hospital bills.

Forty percent of all the patients assumed responsibility for the payment of their hospital charges—surgical and obstetrical patients appeared to be able to assume full responsibility more often than non-surgical patients—and the proportion of patients undergoing surgical treatment tended to be higher in rural than in urban areas.

Of the patients treated prior to hospitalization by private physicians, 73 percent stated they assumed responsibility for the payment of physicians' fees—however, physicians extended credit to 78 percent of these, indicating that even before hospitalization patients experienced difficulty in meeting medical costs.

Less than 12 percent of the patients interviewed reported that their only form of income was from public relief—on the other hand only 36 percent of the families of all patients reporting incomes received \$1,000 or more a year. The distribution of hospital ward patients by annual family cash income is summarized in Chart 14, page 51.

Failure to realize the necessity for medical care and inability to afford a private physician were the predominating reasons by patients who reported delay in securing medical attention; self-medication was reported by 27 percent of the patients, for the most part following the recommendation of another member of the family.

Only 57 percent of the ward patients studied reported having had a physical examination for the illness which brought them to the hospital; periodic physical examinations were reported by only 14 percent.

Forty-seven percent of the obstetrical patients stated that they began their ante-partum care in the sixth month of pregnancy or later; 8 percent received their first medical attention within 24 hours of admission in the hospital for delivery.

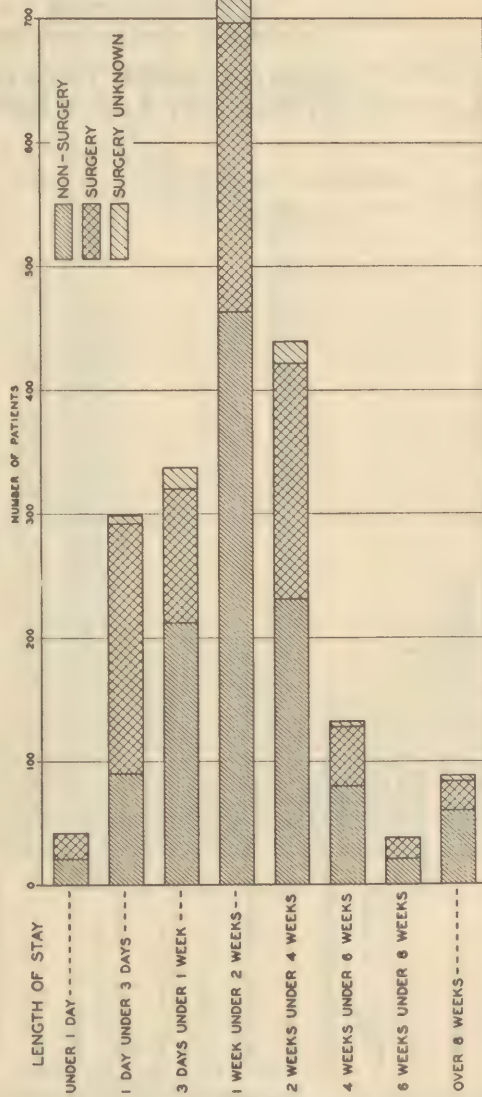
Of the obstetrical patients seen by private physicians during pregnancy, 90 percent reported physical examinations and in 44 percent of these examinations all four of the following procedures were done: blood pressure, urinalysis, blood test for syphilis and vaginal examinations.

Three-quarters of the patients stated that they had medical and nursing attention after discharge from the hospital and such care was provided more frequently in the urban areas.

Hospitalization charges for more than one-half of the ward patients studied were paid from public funds—these patients included those suffering from the more serious and prolonged illnesses.

CHART 10  
 NEW YORK STATE  
 EXCLUSIVE OF NEW YORK CITY  
 HOSPITAL WARD PATIENTS\*  
 CLASSIFIED BY SURGERY AND LENGTH OF STAY IN HOSPITAL

1939



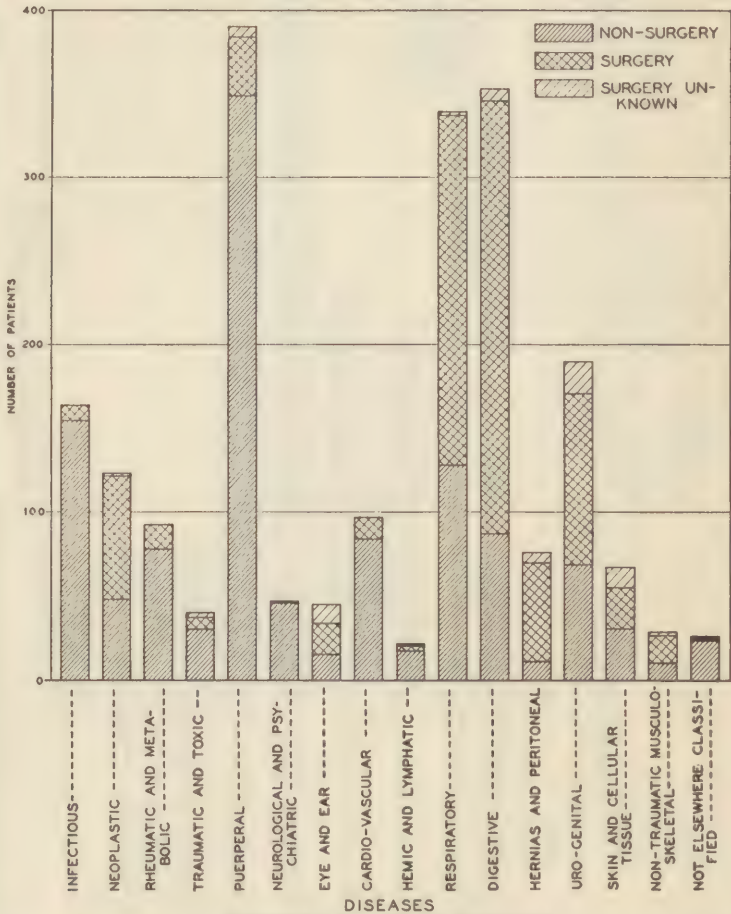
REPORTED FOR 2,093 PATIENTS

\*DATA FROM HOSPITAL AND WELFARE RECORDS

STUDY OF PATIENTS DISCHARGED FROM HOSPITALS

CHART II  
 NEW YORK STATE  
 EXCLUSIVE OF NEW YORK CITY  
 HOSPITAL WARD PATIENTS\*  
 CLASSIFIED BY SURGERY AND DIAGNOSTIC GROUPS

1939



REPORTED FOR 2,099 PATIENTS

\*DATA FROM HOSPITAL AND WELFARE RECORDS

STUDY OF PATIENTS DISCHARGED FROM HOSPITALS



CHART 12

NEW YORK STATE  
EXCLUSIVE OF NEW YORK CITY

HOSPITAL WARD PATIENTS\*  
CLASSIFIED BY RESPONSIBILITY FOR PAYMENT  
AND LENGTH OF STAY IN HOSPITAL  
1939



REPORTED FOR 1,882 PATIENTS

\*DATA FROM HOSPITAL AND WELFARE RECORDS

STUDY OF PATIENTS DISCHARGED FROM HOSPITALS

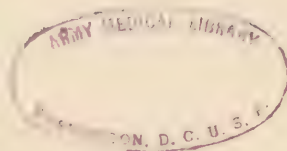
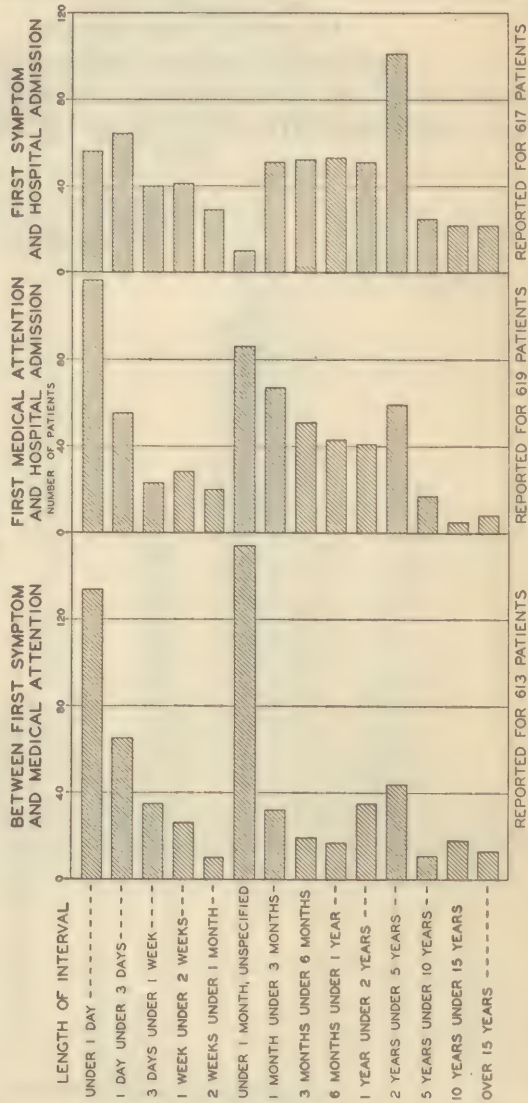


CHART 13  
NEW YORK STATE  
EXCLUSIVE OF NEW YORK CITY

HOSPITAL WARD PATIENTS,\* EXCLUDING OBSTETRICAL,  
CLASSIFIED BY INTERVALS BETWEEN FIRST SYMPTOM,  
FIRST MEDICAL ATTENTION AND HOSPITAL ADMISSION

1939



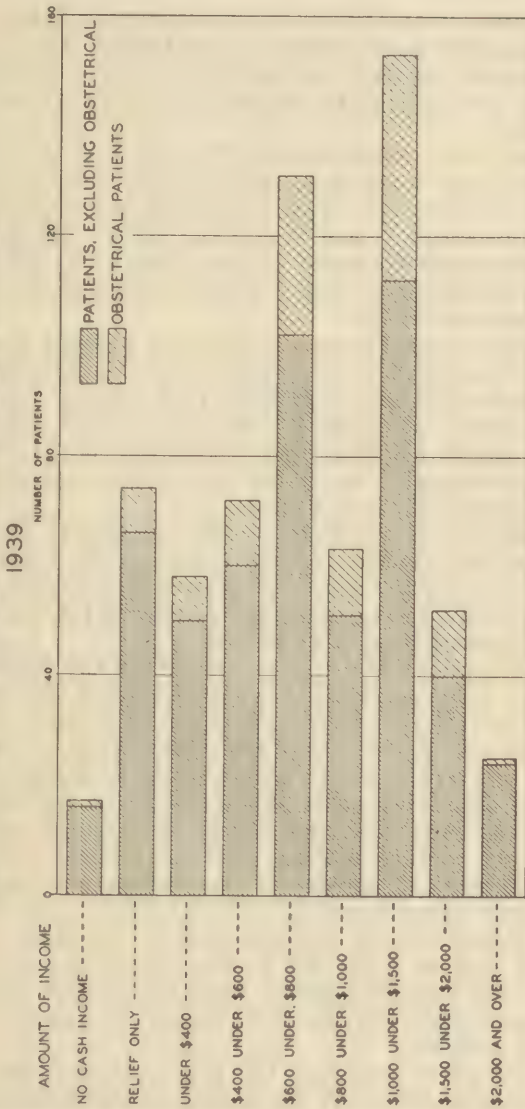
\*DATA FROM HOSPITAL AND WELFARE RECORDS

STUDY OF PATIENTS DISCHARGED FROM HOSPITALS

CHART 14

NEW YORK STATE  
EXCLUSIVE OF NEW YORK CITY

HOSPITAL WARD PATIENTS\*  
CLASSIFIED BY ANNUAL FAMILY CASH INCOME\*\*



REPORTED FOR 645 PATIENTS

\* DATA FROM HOSPITAL AND WELFARE RECORDS

\*\* INCLUDES WPA WAGES, PENSIONS, AND RELIEF ALLOWANCES WHEN SUPPLEMENTING OTHER INCOME

STUDY OF PATIENTS DISCHARGED FROM HOSPITALS



## Study 4

## PAY STATUS OF PATIENTS IN HOSPITAL WARDS AND CLINICS IN NEW YORK STATE, NOVEMBER, 1939

Payments toward the cost of hospital ward and clinic service may be assumed by the patient or his family, they may be accepted by government, or they may be borne by the hospital as a charitable service to the community—dependent upon the economic status of the patient.

A survey was undertaken for the month of November, 1939, to determine upon whom the burden of payment might fall for the care of patients in the wards and clinics of general hospitals in the State. Information was sought to reveal the interrelationship between the economic status of the patient (i. e., the income source: relief, WPA wages, or other) and the assumption of responsibility of the payment for care.

The data collected covered 7,208 ward patients in 63 general hospitals in upstate New York and 12,652 ward patients in 40 voluntary general hospitals in New York City, but the two samples are not strictly comparable because the New York City sample excludes the 26 hospitals operated by the New York City Department of Hospitals, which has the major responsibility for the hospitalization of public charges.

The 63 general hospitals studied in upstate New York had a total ward bed capacity of 3,069, and, of the 7,208 ward patients cared for during the month, one-third were receiving public relief, 5 percent were among families receiving WPA wages and 62 percent had income from other sources.

Over 50 percent of all ward patients in the upstate hospitals in the study were expected to contribute toward the cost of their hospitalization: 86 percent to pay the full ward rate; and, the remainder, the partial ward rate. Forty-four percent of all ward patients were referred to public welfare officials; 84 percent of these had been accepted as public charges at the time of reporting.

Ward patients receiving relief were uniformly (95 percent) referred to welfare officials, and 88 percent were accepted as public charges; 13 percent of the persons not receiving relief or WPA wages were referred to welfare officials (two-thirds accepted), and 80 percent of this group as well as 15 percent of the patients receiving income from WPA wages were expected to pay part or all of the hospital expense. Only 2.3 percent of all the patients were reported as receiving free charity ward service in the upstate hospitals studied.

At the upstate hospitals the per diem rate for ward patients varied from \$2.25 to \$5; the majority ranged between \$3 and \$4; and, all but two hospitals made additional charges for extra services.

The per diem charges made to departments of public welfare for the care of patients accepted as public responsibilities fell in approximately the same range as charges to paying patients. A review of hospital statements regarding specific extra charges made

to welfare departments showed a diversity of practice and extreme variations in charges for specific extra services.

Forty general voluntary hospitals in New York City submitted data which could be utilized in the present tabulation. These hospitals had a total ward bed capacity of 7,778 and reported a total of 12,652 ward patients cared for during the month of November, 1939. The New York City results are not strictly comparable with those obtained in upstate New York since the 26 hospitals operated by the New York City Department of Hospitals were not canvassed. The New York City Department of Hospitals, in addition to maintaining a municipal hospital system, is empowered to consider and accept as public charges, patients both with and without relief status and to reimburse voluntary and proprietary hospitals for their care. Voluntary hospitals, when the patient himself is unable to pay, may elect to apply for such reimbursement, refer the patient to a city hospital for care or accept patients as free charity ward cases.

Of the 12,652 ward patients studied in New York City, of whom 41 percent were expected to contribute toward costs of hospitalization; 12 percent were reported as recipients of relief, 6 percent were supported through WPA wages and 82 percent received income from neither of these sources. More than one-third of the last group, and two-fifths of all the ward patients, were referred to the Department of Hospitals for authorization of hospitalization at public expense. Sixty-one percent of all patients so referred, including two-thirds of the ward patients on relief (12 percent of total), had been accepted as public charges by the end of the month. The voluntary hospitals studied accepted 17.5 percent of all ward patients for free care—and more than one-fourth of these were receiving relief or WPA wages.

In the 40 voluntary hospitals in New York City from which ward rate data were obtained the per diem rate for paying ward patients varied from \$2.50 to \$4.50, the majority between \$3 and \$4; and, all but one hospital made additional charges for extra services.

The data on the pay status and income source of patients attending, during November, 1939, the out-patient clinics of voluntary hospitals, covered 5,329 patients (11,148 visits) in 12 upstate clinics and 32,124 patients (162,204 visits) in 21 New York City clinics. This obviously represents only a fraction of the clinic care given in both areas. Further, extreme caution should be exercised in drawing any conclusions based on a comparison of these two sets of data since the New York City study did not include the extensive free clinic systems operated by the Departments of Hospitals and Health—a type of service which, with one or two notable exceptions is not available in upstate New York.

Keeping in mind the above reservations, the following observations may be made:

The upstate New York clinics rejected 2.1 percent of the patients who applied for care, while in New York City 10.2 percent were rejected, but more than one-half of these were recorded as rejected because they had been referred to, or were already under the care of, other clinics in the city.

One-half of the patients accepted for care at the upstate clinics during November, 1939, were recipients of relief or WPA wages, whereas these groups accounted for only one-fourth of the patients accepted by the New York City voluntary hospital clinics.

Sixty-seven percent of all patients (72.3 percent of visits) accepted by the upstate clinics received free care in contrast to 40 percent of patients (53.3 percent of visits) in New York City.

Clinic fees were paid by 30 percent of the patients accepted in the upstate hospital clinics in November, 1939, compared with 61 percent making such payments in New York City. Public welfare funds paid for clinic fees of 3 percent of the patients accepted in the voluntary hospital out-patient departments in upstate New York. As a matter of policy, New York City does not reimburse voluntary hospital clinics because it operates a municipal system of clinics.

## Study 5

### GRADUATE MEDICAL EDUCATION IN NEW YORK STATE

The education of the physician should never cease. Graduation from medical school marks merely his entry into broader fields of scientific endeavor, both theoretical and practical. Supervised instruction in a modern hospital is a most valuable means of preparing for the intelligent practice of medicine. Contact with recognized medical leaders serves as an inspiration and guide to the young physician in the development of his personality and individual skills. It is practical medical education at its best.

It was the recognition of these factors that led certain schools of medicine to require one year of approved intern training for the degree of Doctor of Medicine and the legislatures of divers states to amend their medical practice acts to require one year of intern training as a prerequisite for medical licensure. New York State, however, does not require one year of intern training for medical licensure, although in 1939, 21 other states, the District of Columbia, Alaska and Porto Rico, had such a requirement.

On April 25, 1939, the House of Delegates of the New York State Medical Society adopted a resolution favoring State legislation creating a one-year internship requirement.

On November 16, 1939, a round-table conference was held at the New York City Academy of Medicine to consider this and allied problems. It was attended by representatives of organized medicine, hospital associations, State departments, the board of medical examiners, the deans of all the medical schools in New York State, and Commission members and staff.

On the question presented, namely, the advisability of State legislation requiring one year of intern training at a hospital approved for this purpose as a prerequisite for medical licensure, the conference registered its unanimous approval. This came after a thorough discussion of all phases of the problem including the adequacy of training facilities, method of their approval, type of



intern requirements desired and of needed educational facilities in a modern hospital.

To orient the Commission on the advisability and effect of legislation requiring one year of internship, the technical staff conducted three inquiries.

*First*, a study to determine the extent to which general hospitals in New York State approved by American Medical Association standards offered an opportunity for training showed that 102 hospitals with 41,870 beds have 1,684 internships; and, 39 of these hospitals are outside of New York City and offer 337 internships.

Of the 102 hospitals, 80 are under voluntary control, 20 under public control (16 being city hospitals), and 2 are proprietary. These public hospitals form 20 percent of all hospitals but offer 39 percent of total intern appointments; in fact, 13 city hospitals in New York City account for 569 or one-third of all internships in the State. In upstate New York 17 percent of the general hospitals which include 42 percent of the total beds, and 25 percent of all voluntary general hospitals representing 51 percent of the hospital beds are approved for intern training.

It should be noted that many general hospital beds are in the infirmaries of Federal and State hospitals which maintain full-time paid medical staffs.

*Second*, since the effect of legislation requiring one year of internship in an approved hospital might be to deprive unapproved hospitals of the services of interns (or residents), a study was made of the 163 general hospitals in upstate New York not on the approved list for training interns. They were sent a questionnaire requesting information concerning their visiting ward service, resident, and intern staffs. In addition, information was requested relative to the medical school, graduation date and previous intern service of all residents and interns.

A tabulation of the replies from 105 hospitals containing 7,715 beds, a representative sample of the upstate unapproved general hospitals, from the standpoint of size and control, showed that 69 hospitals, among which 25, with bed capacities ranging between 50 and 200, had no interns or residents, 2 had interns and residents, 23 had residents only, and 11 interns only. Thirty-one of the 37 hospitals with no attending ward service and 41 of the 58 hospitals with an open visiting staff, did not have an intern or resident. Of 29 physicians serving internships in 13 unapproved hospitals only one had previously completed an approved internship. Six of the 29 had graduated from accredited American or Canadian medical schools, 15 from unaccredited American or Canadian schools, and 8 from foreign schools.

Of 43 residents in 25 hospitals, 6 were graduates of unaccredited American or Canadian schools, 8 of foreign schools and 38 reported approved internships before becoming residents.

In the sample studied, only 28 physicians without previous approved internships, interns in hospitals unapproved for intern training, would be affected by legislation making one year of approved internship compulsory; and, only 13 hospitals might find

difficulty in securing interns under the same circumstances. Out of 72 interns and residents reported in hospitals unapproved for intern training in upstate New York were 21 graduates of unaccredited medical schools and hence legally not eligible to practice medicine in New York State.

*Third*, to ascertain how many licensed physicians in New York State have had one year of approved intern training, although the same was not required for medical licensure, a study was made with the aid of the American Medical Association of the intern experience of physicians licensed to practice medicine in New York in 1937 and 1938. A tabulation of individual records showed that out of 3,261 physicians licensed to practice during 1937 and 1938, 771 had not completed or had no record of internship and 202 had interned in hospitals unapproved for intern training. Of the 771, 581 (75.3 percent) were graduates of foreign medical schools. In 1937, 5.5 percent, and in 1938, 6 percent, of the American and Canadian graduates were not recorded as having completed a year of intern training; and, during the same years, 1,404 (65 percent) of the 2,161 completed approved internships were served in New York State hospitals.

It was noted that in 1937 and 1938, 23 graduates of medical schools non-accredited in New York State achieved New York licensure by endorsement of licenses issued in other states.

Adoption of an internship requirement by New York State would have its greatest effect on physicians who are not graduates of American and Canadian schools.

The round table conference discussed another question dealing with the advisability of the establishment at the State level of a voluntary register of medical specialists, endorsing such a proposal in principle but recommending that, for the present, such registration and endorsement of specialists be left with the non-governmental groups active in such work.

As a result of these studies two bills were prepared and submitted to the State Legislature. One,<sup>1</sup> designed to require the completion of a one-year internship approved by the Department of Education as a prerequisite for license to practice medicine in New York State, was introduced in the Senate and Assembly by Mr. Mahoney and Mr. Mailler, respectively.

The second,<sup>2</sup> designed to protect the public against the practice of medicine by graduates of unaccredited medical schools as interns or residents in hospitals in New York State, was introduced in the Senate and Assembly by Mr. Mahoney and Miss Todd, respectively.

The quality of medical care, so difficult of supervision, is as important as its system of distribution. Good medicine requires trained and ethical practitioners.

Legislative proposals, within reason, are one means of creating formal standards to safeguard and improve such quality.

<sup>1</sup> This bill was passed by the 1940 Legislature and vetoed by the Governor.

<sup>2</sup> This bill became law April 26, 1940. (Chap. 761, Laws of 1940.)

## Study 6

### HEALTH INSURANCE

This study is devoted to a detailed consideration of insurance, voluntary or compulsory, as one of the methods for the distribution of medical care.

The Commission immediately recognized that while compulsory health insurance is one of the methods of distributing medical care, it is primarily a procedure for pooling funds contributed by insured persons and their employers, using such funds to pay for such medical care and to provide cash benefits to the insured during the periods of disability. It was recognized by the Commission that the medical needs of wage earners, including their dependents, in fixed income levels, could be met in many ways which differed, one from the other, both with respect to the scope of medical services provided and the methods by which such services were distributed, supervised and paid for.

Compulsory health insurance, therefore, should be considered in the light of its development in foreign countries, the applicability of such development to New York State, and its relationship to other methods of distributing medical care which might be more appropriate to conditions prevailing in New York State. Hence, the studies made by the Commission of existing and proposed schemes for public provision of medical care, and studies of voluntary hospital services and medical care insurance programs should be carefully weighed, together with the private practice of medicine, in the evaluation of this study of health insurance.

"Health Insurance," voluntary or compulsory, may be defined as a method of pooling risks and resources to budget and pay the costs of medical care and/or compensate for loss of earnings due to disability. The organization of many people under a single plan is considered necessary to pool the risks. The technique of small periodic prepayments is a method used to pool the resources.

Two procedures can be used to apply the insurance principle to medical care: voluntary cooperation of a number of individuals or groups; or a governmental requirement that certain economic or occupational groups join a scheme safeguarded, guaranteed and assisted by law.

There is no innate relationship between the mechanism of distributing medical care and the method of paying for the costs of such care.

Services may be distributed on the basis of the individual or group practice of medicine and paid for through a prepayment arrangement.

Group practice may be defined as the cooperative practice of medicine by physicians for the purpose of pooling experience, equipment and earnings.

"On the economic side, a wisely arranged association of general and special practitioners will obviously have the result of making possible very large savings in overhead, which, today, particularly



in the case of the specialist, has become a very important charge against his gross income. That this does, in fact, occur has been frequently denied, chiefly by the various groups commonly referred to as 'organized medicine.'"<sup>1</sup>

The proponents of the individual practice of medicine believe that group practice, especially on an insurance basis, will result in an undesirable limitation to the patient of free choice of his physician, as well as an impairment of the quality of medical care provided through a system of regimentation and lay control.

The platform of the American Medical Association advocates "The continued development of the private practice of medicine, subject to such changes as may be necessary to maintain the quality of medical care and to increase its availability."

While the primary purpose of health insurance is to provide means of budgeting to meet the costs of needed medical care, it is important to keep in mind the wage classes of the employed population who might be covered as well as the trends in the net incomes of physicians.

In New York State, of the approximately four million employees covered by the old age insurance provisions of the Social Security Act, in 1937, 56.2 percent were in wage classes of under \$1,000 per year, and 86.4 percent in wage classes under \$2,000 (*Monthly Social Security Bulletin*, April 1939, p. 17).

In 1929, complete specialists had an average net income of \$10,000; partial specialists of \$6,100; general practitioners of \$3,900. Fifteen percent of the general practitioners earned less than \$1,500 and 30 percent less than \$2,500 (*Committee on the Costs of Medical Care*).

In a paper recently delivered before the meeting of New York County Medical Society on Economic Conditions of Physicians in New York City, Dr. Ernest P. Boas pointed out that the most recent studies show a tremendous drop in income from the year 1929 to 1933, a "drop that reaches between 50 percent and 60 percent. I have obtained from the Bureau of Medical Economics of the American Medical Association the data that they have available. They represent surveys made in many parts of the country, in small and large communities. From a consideration of all the figures, I believe that it is fair to estimate that the average net income of the general practitioner in the year 1936 was about \$3,500—the median was less."

## VOLUNTARY HEALTH INSURANCE

### Sponsors of Voluntary Health Insurance

There is a great variety of organizations which may assume—in fact, have already assumed—responsibility for developing voluntary plans based on the application of the insurance principle.

<sup>1</sup> Cabot, Hugh. *The Doctor's Bill*. Columbia University Press, N. Y., 1935, p. 69.

The sponsors may be classified by their approach: one group handles different types of plans on a commercial or profit basis; the other group sponsors non-profit arrangements.

Outstanding examples in the first group are commercial insurance companies, writing either individual insurance or group insurance. Well-known sponsors in the second group (listed in the order of historical development) are mutual benefit associations, fraternal orders, industry and business, unions, colleges and universities, consumer cooperatives, voluntary agencies, medical societies and other groups of physicians.

It is hard to describe common elements in all of these developments because of the great variety of pioneering organizations and the widely varying type of approach. However, there has been a definite trend towards developing the contributory principle and emphasizing the provision of services.

### **Non-profit Free-choice Plans Offering Insurance against Costs of Hospitalization**

The technique of insurance against the costs of hospitalization has been used on a broad basis by the establishment of non-profit free-choice plans for hospital care. The basic principle of these plans is group budgeting of hospital care by group prepayment.

This movement dates back to 1929 when Baylor University, in Dallas, Texas, made an agreement with 1,500 school teachers to provide three weeks' hospitalization in return for a fixed prepayment. The idea spread rapidly, particularly during the last five years. By January 1, 1940, there were 60 non-profit free-choice hospital plans in operation for about 4½ million people as contrasted to one plan with 2,000 members in 1933. Plans of this type were given legal status in New York State by legislative action in 1935. So far, 24 states, representing a population of about 88 million, have passed enabling acts for non-profit hospital service plans. Nine states have ruled, through their attorneys general or departments of insurance, that non-profit hospital service plans are not "insurance" and have permitted them to operate under the general corporation laws, exempt from the regulations covering stock and mutual insurance companies.

The "Associated Hospital Service of New York," established in 1935, is notable for its large enrollment, covering 1,358,000 people in the 17 counties in the metropolitan area by January 1, 1940. Other plans covering New York State have headquarters in Rochester (coverage 131,427 persons); Syracuse (coverage 92,565 persons); Buffalo (coverage 96,893 persons). In addition, plans are in operation from Albany (coverage 44,237 persons), Geneva, Jamestown, Utica (coverage 51,367 persons) and Watertown.

Trends and developments in this field are revealed in the experience of the "Associated Hospital Service of New York"<sup>2</sup> which "has grown to the position where it is paying eight million dollars

<sup>2</sup> Report of Progress (1940).

a year for the hospital care of subscribers. Hospital bills totalling more than sixteen million dollars have been paid by this voluntary non-profit plan since it was established five years ago.

"With an enrollment of more than 1,350,000 persons, or one out of six in the New York area, Associated Hospital Service is the largest of 60 non-profit hospital plans throughout the United States. The number of our subscribers increased more than a quarter of a million during 1939."

The developing of non-profit free-choice hospital plans, sponsored by a group of participating member hospitals and community representatives, is highly significant and important. It stimulates general interest in the method of prepayment for medical care; emphasizes the provision of services rather than cash indemnity; shows how the financial burden of high cost illness, usually requiring hospitalization, can be alleviated for the patient, and tends to give the physician more freedom in suggesting types of treatment, hitherto not easily accessible to many patients.

Hospitals also benefit from these new plans—through assurance of a regular and substantial income. It has been a noble tradition of voluntary hospitals to use surplus income from high cost private room accommodations together with revenues from philanthropic sources to provide free care. A steady decrease in the use of private rooms and in hospital income from philanthropy, together with increasing demand for free care, ward service, and semi-private accommodations brought many voluntary hospitals into financial distress. During a sample month in 1930, among 150 voluntary hospitals in New York City, one-third of the private and semi-private beds were empty and in 1934 one-half.<sup>3</sup>

Yet, for the patient and the community, existing group hospital plans meet only a part of the need. Payments for the services of physicians as well as hospitalization for socially important diseases or conditions are excluded from the plans. The duration of hospital service is limited, old people usually cannot qualify as subscribers, and the service as it stands is accessible only to the economic groups of the population eligible to subscribe and able to pay the premiums.

### **Prepayment Plans for Medical Care, Covering Physicians' Care or a Variety of Services**

*General Characteristics.*—The rapid development of prepayment plans for hospital care clearly indicates the public's strong interest in the method of insurance. Both the achievements and the shortcomings of non-profit free-choice hospital plans appear to have accelerated efforts to develop similar mechanisms for services other than hospital care.

In various parts of the country prepayment plans covering a variety of fundamental medical services have been in operation for a number of years and new programs are announced each

<sup>3</sup> Davis, Michael M., *Tough Facts About Hospitals*, The Survey, July 1937, pp. 219-220.



month. These plans may be roughly classified in two groups: First, there are service plans in operation offering physicians' care at home, office and hospital, dentists' care, hospitalization, ambulance service, laboratory services, x-ray services, physical therapy services, drugs and bedside nursing at home, or a varying combination of a number of these services. Second, there are plans based on the principle of reimbursement of cash indemnity for physicians' care exclusive of other services or in combination with group hospital plans. The first mentioned type of plan usually is operated on the basis of group practice and sponsored either by groups of consumers or groups of physicians. Some examples are "The Farmers Union Cooperative Hospital Association," Elk City, Oklahoma; "Stanocola Employees' Medical and Hospital Association," Baton Rouge, La.; "Group Health Association," Washington, D. C.; "Greenbelt Health Association," Greenbelt, Md.; "Centro Asturiano," Tampa, Fla.; "Ross-Loos Medical Group," Los Angeles, Cal.; "Milwaukee Medical Center," Milwaukee, Wis.; "Trinity Hospital," Little Rock, Ark.

The second type of plan, providing "cash indemnity" for medical expenses is conducted on the basis of individual practice and is usually sponsored by a local organization of physicians. Some examples are: "The King County Medical Service Bureau," Seattle, Wash.; "Medical Service Bureau," Atlanta, Ga.; "Columbia Medical Society Mutual Health Association," Washington, D. C.; "Western New York Medical Plan," Buffalo, N. Y.; "Medical and Surgical Care," Utica, N. Y.; "Associated Health Foundation," New York City.

"Cash indemnity insurance plans to cover, in whole or in part, the costs of emergency or prolonged illness" have been advocated by the American Medical Association which officially opposes most of the prepayment plans linked with group practice.

#### **Development of Enabling Legislation in New York State (Article IX-C, Insurance Law), with Additional References to such Legislation in other States**

In New York State the first practical and widespread application of the principle of non-profit voluntary health insurance was put into statutory form by the enactment of Article IX-C of the revised insurance law of the State of New York.

*Progress under IX-C:* The following three plans had been licensed by the Superintendent of the State Insurance Department before this report was submitted:

- A. Medical and Surgical Care, Inc., Utica, New York.
- B. Associated Health Foundation, Inc., New York City.
- C. Western New York Medical Plan, Inc., Buffalo, New York.

Article IX-C in its broad interpretation allows for the organization of a non-profit corporation to provide medical or hospital expense, or indemnity to subscribers with reimbursement to physicians for medical care services on a fee-for-service or per capita

basis. The law at present limits the experimental field in medical care plans from two broad points of view:

1. A corporation cannot be organized to provide both medical care expense indemnity and hospital care expense indemnity .

2. Article IX-C, Section 250, provides that every such plan shall be open to the participation of duly licensed physicians without discrimination against the schools of medical practice defined in the Education Law.

This is interpreted as prohibiting the licensing of medical service plans whose subscribers are to be serviced by a closed and selected group of physicians. Despite the limitations of the present statutes, in New York State as well as other states, there have been developed medical care plans operated on the basis of group practice and financed by prepayments as well as fees for service.

Enabling acts for medical care corporations on a non-profit basis were passed during the 1939 legislative session in the states of Michigan, Connecticut, Pennsylvania and New York. In at least 11 other states similar bills were introduced. The laws passed so far have considerable similarity. However, it is only in the New York State statute that the term "Medical Expense Indemnity" is used. The statutes in the other states simply refer to the furnishing of medical service to subscribers under contracts, entitling the subscriber to such service at the expense of the corporation. It should be noted that only one state, Pennsylvania, provides for supervision by the Department of Health, with regard to quality of the medical care furnished to subscribers.

## Description of New Forms of Medical Service

### *Examples of Group Practice:*

1. Diagnostic service, organized and administered by a group of physicians, financed on the basis of an all-inclusive flat fee: Mount Sinai Hospital, New York City. This consultation diagnostic service was established in 1932 as an experiment in placing the professional and physical facilities of the Mount Sinai Hospital at the disposal of the practicing physicians of the community for the study of obscure or complicated diagnostic problems among their patients of moderate means. It is an independent, detached unit of the hospital, not a part of the out-patient department. A patient must be referred by his physician, and admission is granted only to patients with incomes of less than \$4,000 per year.

The work is limited exclusively to diagnosis. A flat fee of \$35 is charged for every patient regardless of the nature of his illness or the number of consultations or laboratory examinations required. A report of the findings, together with suggestions for treatment, is forwarded to the patient's private physician upon the completion of the diagnostic work-up.

2. The Union Health Center, New York City. Several local units of the International Ladies Garment Workers Union inaugurated a cash benefit system for sickness about the year 1913.

In 1913 a group of labor unions in New York City joined forces to establish a low price dental clinic, known as the Union Health Center.

In 1928 the service was expanded by the addition of medical care. A clinic of six doctors was established, with facilities for health examinations and medical treatment for members of the union.

The Union Health Center derives its income partly from the union whose members use its facilities and partly from the patients themselves. Some

local units operate benefit systems and pay for all the medical care extended to their members, for examination of applicants prior to their acceptance as members, and for home visits, if and when members are unable to come to the Center. The members who do not come under this heading but wish to secure medical care at the Union Health Center pay nominal fees, generally \$1.

Since May, 1934, the International Ladies Garment Workers Union has assumed full responsibility for the finances of the Union Health Center. This union in New York City alone has a membership of more than 100,000 men and women.

3. The Medical Care Program, conducted on the basis of group practice and financed by both prepayments and fees for service. Ross-Loss Medical Group, Los Angeles, Cal.<sup>4</sup>

The Ross-Loos Medical Group was originally organized in 1929 in Los Angeles, Cal., to render medical service to the employees of the Department of Water and Power of the city. The service was expanded when contracts for service were signed with other employed groups, and in 1936 the Group leased a four-story building to house the growing clinic.

Financial and professional arrangements between the clinic and groups of subscribers are negotiated by specially organized health committees. At the present time, there are approximately 21,000 employed subscribers representing more than 110 different groups of persons, constituting with their families more than 60,000 people.

The Group is owned and operated by a medical partnership of 19 of the 69 full-time staff physicians. The staff has its offices either in the main clinic or in one of the 10 branch clinics located in the suburbs. The facilities have been specially designed for the particular type of practice engaged in.

For \$2.50 per month under the group enrollment plan<sup>5</sup> the clinic agrees to provide for the subscriber medical services of general practitioners, specialists and surgeons in the home, clinic or hospital. Services also include laboratory work, x-ray services, physical therapy treatment, eye refractions, drugs and dressings, and hospitalization. Dependents of members may receive all professional services at 50 cents each for office call, \$1 for each resident call and other small charges for special procedures, such as \$25 for a major operation. The average charges for service to dependents is 81 cents per month per family. The average of 15.8 office calls (excluding calls for operative procedures) per year per average family of 3.2 persons indicates the volume of service rendered.

4. Medical Care Program, conducted on the basis of group practice by an industrial corporation.

The program sponsored by a big industrial company as one of a variety of its general welfare activities, serves the employees of the plant and their family dependents, totalling about 51,000 persons in 1938. The program is all-inclusive and operated without any restriction. Type, scope, amount and quality of medical care meet high standards. In the year 1937-38 the total costs of the medical care program, excluding money value of rent, cost of administration, taxes, and depreciation, averaged \$17.40 per person eligible for service. The adjusted costs, covering the aforementioned items and excluding depreciation, may be estimated as ranging from \$20.50 to \$21.80 per eligible person per year. The costs of hospitalization were \$7.55 per person and \$74 per hospitalized case. The costs of drugs were \$1.76 and \$1.98 per person, excluding and including pharmacists' salaries; the average cost of an order filled at the pharmacies was 35 cents. The expenditure for hospital care accounted for about one-third of the total (adjusted), that for drug supply for about 9 per cent, including the salaries of the pharmacists.

5. Summary of a study of five medical care plans.<sup>6</sup>

<sup>4</sup> Law and Contemporary Problems, Medical Care, School of Law, Duke University, Vol. VI, Autumn, 1939, No. 4.

<sup>5</sup> Individuals may now subscribe on a non-group basis for service at \$3 per month premium.

<sup>6</sup> Condensed from Goldmann, Franz, M.D., Costs of Group Health Service. A comparative study of five plans of organized medical care of self-supporting people.



During the years 1939 and 1940 five established medical care programs operating in different parts of the country were studied in detail. All of them use group practice to furnish medical services varying in type and scope. All of these programs operate around central clinics. The programs differ, however, in the ways they are financed. Two plans operate exclusively on prepayments, two use prepayments in combination with certain payments on a fee-for-service basis, and one, operated by an industrial corporation, provides medical care free of charge to employees and their dependents.

The striking differences in the costs of these plans appear to be due primarily to three factors:

First, the services of the programs with relatively higher costs are sought for most part by people who are eager to avail themselves of the facilities offered at favorable terms. The subscribers are adversely selected "risks" because people actually in little need of service do not join in a sufficiently large number. The groups covered by these plans represent only a small fraction of all the people living in the respective areas. On the other hand the plans operating on an average per capita cost of \$21 and \$12, respectively, are organized for service to cross-sections of a certain economic, occupational, and social class constituting a substantial proportion of the population in the respective communities. The differences in their costs are mainly due to variations in scope and amount of services.

Second, the uneven spread of risks under the one group of plans as contrasted to the fair distribution of risks prevailing under the other, results in quite different demands for service and wide variations in the number of physicians needed.

Third, the size of the various groups covered ranges from approximately 5,000 to more than 50,000.

All the plans investigated show a definite trend to decrease in per capita cost when the number of people covered increases. Furthermore, the average cost of the all-inclusive program for large unselected population groups is lower than that of the limited programs for small selected groups.

### *Example of Individual Practice:*

#### 6. Western New York Medical Plan, Inc., Buffalo, New York.

Area to be served—Counties of Allegany, Cattaraugus, Chautauqua, Genesee, Niagara, Orleans, Erie and Wyoming. This corporation proposes to issue contracts to groups of subscribers on a payroll deduction basis, with membership limited to those earning less than \$1,800 for an individual, \$2,500 for man and wife and \$3,000 for family.

#### *Rates:*

A—Individual subscriber \$18 per year.

B—Man and wife \$27 per year.

C—Full family coverage, man and wife and all unmarried children under 19 years of age, \$36 per year.

*Benefit Deductions:* This plan has a deductible feature inasmuch as the subscriber must pay the physician for one-half of the fees amounting to a total of the first \$20, in non-surgical cases and for house and office calls in any contract year. The purpose of this clause is to prevent the subscriber from going to the physician for inconsequential matters.

#### *Medical Indemnity Limits:*

A—For the individual subscriber \$200 for one year.

B—Man and woman \$300 for one year.

C—Full family coverage \$400 for one year.

#### *Medical Benefits Exclusions:*

A—Workmen's compensation cases.

B—Elective operations for the first year of contract.

C—Venereal diseases during the first 11 months of the contract.

D—Any ailment arising from the use of drugs and alcohol.

E—All functional nerve and mental diseases in excess of \$50.

F—Obstetrical service during the first year of contract and extra specialist fees above \$50 per confinement after the first year.

G—Services rendered during diagnostic investigation or study founded on definite evidence of disease or injury.

H—Treatment of congenital diseases.

I—Services rendered for any ailment known to exist prior to the date of application.

J—Injury or diseases contracted in the commission of felony.

K—Intentional self-inflicted injuries.

L—Services to individuals who have had prior to application the following:

Cancer

Diabetes

Osteomyelitis

Tuberculosis

Coronary thrombosis

Chronic nephritis

*Reimbursement of Physicians:* This plan expects to pay doctors on a fee basis, with the doctors agreeing to accept a pro rata share of income if funds are insufficient to pay in accordance with fee schedule.

### Achievements and Shortcomings of Voluntary Health Insurance

The various efforts to develop voluntary health insurance deserve high commendation. "The proof of their value, however, is not their good intentions" but a careful examination of their actual accomplishment and future prospects.

*Coverage*—Both the economic and occupational status of the people actually covered by the various voluntary health insurance plans in operation can be fairly well described. The majority of the people who have enrolled in group hospital plans belong to families with moderate incomes. A study conducted by the Associated Hospital Service of New York demonstrates that "80 percent of the subscribers to this plan not only in New York, but in other parts of the State even more, have incomes of less than \$2,500 a year. This indicates that this plan does meet its original purpose of serving the person of modest income. The group enrollment regulations under this plan provide that those persons who earn less than \$1,000 a year be excluded from enrollment requirements. While such persons are not debarred from enrollment, they are not urged to do so because generally such persons are unable to obtain the services of a personal physician and consequently represent the segment of the population which should receive free services in hospitals and from the medical profession."

Occupationally most of the subscribers are either high-paid skilled workers or white-collar workers and professional people. It is important to note that often the family, rather than just the wage earner, has made use of the offer to subscribe.

The services of prepayment plans conducted on the basis of group practice are primarily sought by families with incomes above \$1,500 and below \$3,000. The percentage of families with lower incomes is relatively small.

There is no accurate information as to the economic condition of people subscribing to cash indemnity plans. However, it seems fair to assume that few subscribers to cash indemnity plans would come from low income groups.

<sup>7</sup> Pp. 658-659 Report of the Public Hearings, N. Y. S. Temporary Legislative Commission to Formulate a Health Program, Dec. 15-16, 1938.

The total number of persons actually covered by various plans can be estimated only very roughly. Group Hospital Plans have reached approximately 4½ million people in this country. Prepayment plans for medical care, offering physicians' care or a variety of services to the general public, probably serve a few hundred thousand persons. Medical care programs, operated for employees of industrial or business firms and financed either by employers or employees, may cover a few million persons. Furthermore, about eight million wage earners may carry some form of insurance against temporary disability with private insurance companies, and a larger number of industrial insurance policies is in force covering death or permanent disability.

It is claimed that voluntary insurance against the economic risks of illness is primarily used by people who are fortunate enough to enjoy such an income as to permit savings including prepayments for some protection from illness.

Some students of the subject believe that on the basis of actual experience in this country<sup>8</sup> three factors appear to have had a decisive bearing on the enrollment by the general public in prepayment plans. First, many people "preferred taking a chance to budgeting ahead because they relied on their previous good health record." Second, "there was—and still continues to be—a big turnover of subscribers; the result was concentration of persons in ill-health and loss of persons in good health," with the implication of uneven spread of risks and relatively high average costs to many plans. Third, people interested in budgeting for medical care saw no profit in many of these propositions because the "premiums" were disproportionate to the value of the services offered.

*Scope of Service.*—Commercial insurance policies offer some protection from economic distress by reimbursing policyholders in the event of accident, sickness, disability and death. However, often the policies are so restricted as to cover only fractions of the wages lost. The reports received by this Commission from insurance companies writing group accident and health policies confirm the findings made by the Illinois Health Insurance Commission about 20 years ago. Although 25 percent of the wage earners examined in 1919 were found to be insured by group accident and health policies against loss of wages, only 13 percent of those who lost wages for one week or longer received compensation for a part of their losses, and only 6 percent of the total wages lost were recovered.

The development of non-profit plans for hospital care is highly significant and important. Experience shows that patients, hospitals and physicians are benefited. However, there remains the fact that for the patient and the community existing group hospital plans meet only a part of the need because payment for the services of physicians as well as hospitalization for socially important diseases of conditions are excluded from service.

<sup>8</sup> Goldmann, F., *Costs of Group Health Service*. A comparative study of five plans of organized medical care for self-supporting people.



*Prepayment Plans for Medical Care.*—Organizations established on this basis have attempted to make contributions to the solution of the medical care problem by providing for the large variety of services necessary to restore and maintain health. They are based on both the individual and group practice of medicine. However there are frequent restrictions as to type of illness or type of service covered under the prepayment arrangements. If a problem exists for providing good medical care, both in quality and quantity, existing experimental plans are too small in number to be a decisive factor in community health programs.

Few prepayment plans for medical care, conducted on the basis of individual practice, are actually in operation. Article IX-C of the State Insurance Law provides for prepayment plans conducted on the basis of individual practice, and plans proposed reveal certain facts relating to scope of service. Not only is service restricted to physicians' care, but physicians' care is incompletely covered. The "deductible clause," used in a number of "cash indemnity" plans, tends to inhibit the practice of preventive medicine, and the long list of diseases exempted from indemnity greatly decreases the potential value of such service.

*Costs.*—Commercial insurance companies offer individual or group insurance at rates beyond the reach of people in low income groups. Often the premiums represent more than 5 percent of the workers' income yet entitle him to only limited reimbursement.

Non-profit plans for hospital care charge fees from 50 to 85 cents per month per individual or from \$1 to \$2 per month per family. Dr. I. S. Goldwater, Commissioner of Hospitals of the City of New York, in testifying at the public hearing<sup>9</sup> before this Commission, stated:

"I believe people earning \$1,500 or more who are regularly employed could help themselves out so far as hospital service is concerned, by joining these insurance plans. I believe there are many families with an income of \$1,200 to \$1,500 who have no money for hospital care and who are entitled to get it."

This statement clearly indicates that the burden of prepayments for hospital care is too heavy for individuals comprising large groups of the population. It has been suggested by some experts that these prepayment plans be extended to include hospital care on a ward basis.

Proponents of voluntary health insurance feel that under any acceptable plan both hospital and medical care should be furnished. Since the non-profit hospital plans have already had considerable experience their rates may be taken as a standard for hospital care. To these rates for group hospital plans we have to add all the other expenses of sickness to be borne by the patient. Under the incorporated non-profit medical expense indemnity plans in this State there would be additional costs to \$16.80 to \$18 for a single subscriber, bringing the total near to \$28. For a family with two

<sup>9</sup> Minutes of the Public Hearing, N. Y. State Temporary Legislative Commission to Formulate a Health Program, Dec. 13, 1939, Vol. 1, p. 30.

children under 16 years the various plans would require prepayments for physicians' care ranging from \$36 to \$45, bringing the total up to \$60-\$69. Even this expenditure, however, would not guarantee complete medical care; the patient would have to pay extra for the respective amounts excluded by the deductible clause, treatment of illnesses not covered by the contract, drugs and appliances, dental services, bedside nursing at home and in some instances even night calls. The total annual cost of both hospital care and medical indemnity under some proposed plans might be so high that it would be prohibitive for the great mass of the population.

Proponents of group practice claim that the total average costs of medical care under prepayment plans combined with group practice range from about \$12 to approximately \$30 per eligible person per year. This figure includes all expenses to the patient for physicians' care by both general practitioner and specialists, dentists' services, laboratory services, diagnostic and therapeutic x-ray services, physical therapy services, drugs and some appliances, hospitalization—subject to restrictions—ambulance service and bedside nursing at home. It is claimed that an average of \$20 to \$22 per eligible person per year appears to be necessary to operate an all-inclusive prepayment plan for groups of people, and a lower rate to furnish all the necessary "fundamental" services subject to certain restrictions. However, it seems this can be done only if group practice is used and large unselected population groups are covered. The practicability of interesting such large unselected population groups in suitable coverage may well be questioned. The answer will probably be found in the future experience with voluntary plans.

*Administration.*—There are prepayment plans which are administered by physicians only. Others are operated solely by the consumers or subscribers. The democratic principle of self-government requires that responsibility for administration is shared by all groups concerned. In other words, both physicians and potential patients should be represented adequately on a board of trustees. Many prepayment plans have by-laws defining the spheres of influence of laymen. A typical example of such a by-law is the following:

"The Board of Trustees shall in no way regulate or supervise the practice of medicine by any physician with whom it arranges for the care of members, nor shall it in any way supervise, regulate, or interfere with the usual professional relationship between such physician and his patient member, and every such agreement entered into by and between a physician and the Association shall contain a positive covenant to that effect."

However, under any plans, proposals involving medical policy should be developed only with the advice and guidance of qualified physicians.

*Standardization.*—Central guidance and standardization is imperative to avoid waste of efforts and money. The American Hospital Association by issuing "Essentials of an Acceptable Plan

of Group Hospitalization" in 1933 and by establishing a "Council on Hospital Service Plans" in 1938, has taken important steps to coordinate the movement towards plans for hospital care.<sup>10</sup> The Bureau of Cooperative Medicine was founded in 1936 to give "instruction and advice on the organization of health associations by groups of people who wish to obtain medical service on a cooperative basis." The Group Health Federation of America was founded in 1939 for the purpose of establishing and maintaining standards of practice and organization of group health plans. The American Medical Association is making studies of the various forms of voluntary health insurance prepayment plans now being organized by State and county medical societies, in many states, in order to compare them with respect to the extent to which they meet the need for improvement in the distribution of medical care.

*Supervision*—is still far from satisfactory. Bankruptcies obviously would discredit all efforts to develop voluntary health insurance. In addition, supervision as to quality of medical care appears to be an urgent necessity so as to prevent medical care programs from functioning unless they maintain proper standards. In most of the states, hospital plans are under the supervision of Departments of Insurance, and in some instances Departments of Health and Welfare also participate. In New York State supervision from the fiscal standpoint is maintained by the Superintendent of Insurance. In addition, the Certificate of Incorporation for non-profit medical care plans organized under the Membership Corporations Law must have the approval of the Department of Social Welfare.

*Legislation*.—At present insurance laws in many states do not allow experimentation with new forms of medical practice and new methods of finance. New York State has enacted enabling legislation for the formation of non-profit medical expense indemnity corporations. The law at present limits the experimental field in medical care programs by prohibiting, first, a combination of physicians' and hospital care under "expense indemnity" plans and, second, development of service plans conducted by a closed and selected group of physicians. Among proposals in other states the Wisconsin Bill seems to offer the widest possibilities for further experimentation.

Voluntary health insurance, as actually used on the commercial level as well as on a non-profit basis, should prove to be of value to those people who are not always in urgent economic need if sickness strikes them. However, these groups represent only a small proportion of the total population. It is fair to assume that most of the subscribers to voluntary plans have annual incomes exceeding \$1,500; probably the income groups over \$2,000 will be predominant in membership lists. But families and individuals with annual incomes from \$1,500 to \$3,000 represent only about one-fourth of the population. About one-third of the families and individuals are in the income brackets from \$750 to \$1,500,

<sup>10</sup> Approved Program and Standards, The Commission of Hospital Service, American Hospital Association, Second Revision, 1939.



and approximately another one-third earn less than \$750. Unless drastic changes are made in voluntary health insurance plans and they are subsidized by the State or private charity, it is difficult to see how they can possibly meet the medical needs of persons earning less than \$1,500 per year.

Voluntary insurance against the economic risks of illness has been said to have "nowhere shown the possibility of reaching more than a small fraction of those who need its protection."<sup>11</sup> In 1932 a minority of the Committee on the Costs of Medical Care made the warning statement: "Voluntary insurance will never cover those who most need its protection. No legerdemain can bring into a voluntary system the unorganized, low paid working group who are not indigent but live on a minimum subsistence income. Yet any plan that helps those with less serious needs and does not reach those whose needs are sorest does not solve the fundamental problems of providing satisfactory medical service to all."

Whatever may be done to fill the present gap, voluntary prepayment plans will still be needed. They are susceptible of certain expansion and ought to be developed—along sound lines and in a socially desirable direction. For the income groups able to subscribe these voluntary plans may furnish the solution to the problem created by the burden of unpredictable illness. There should be wide experimentation with all types of voluntary health insurance to determine the most suitable plans for different groups of the population—and how they can be integrated with existing public and private facilities for the distribution of medical care. Voluntary health insurance can contribute its share to a broad health program for all of the people; standing alone it cannot possibly solve the Nation's health problems.

### COMPULSORY HEALTH INSURANCE

This summary of compulsory health insurance abroad gives a birdseye view of foreign developments. It is intended to describe common elements rather than details of national policies and laws. Because of this approach the presentation cannot possibly cover all aspects. However, stress is laid on such principles as are considered relevant to current American discussions on the subject. Several American authors have written excellent books which go into the details of foreign schemes, analyze their operation, and evaluate their achievements and shortcomings.

#### Characteristics of Required Programs as Contrasted to Voluntary Plans

There are three major points of distinction between required and voluntary health insurance programs.

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<sup>11</sup> Report of the Technical Committee on Medical Care of the Interdepartmental Committee to Coordinate Health and Welfare Activities, Washington, D. C., 1938.

First, under compulsory schemes, individuals are required to budget for their sickness costs instead of being free to join or leave a group serving mutual purposes. Second, under compulsory schemes individuals are required to put aside in advance small amounts of money to meet the burden of illness by regular prepayments. Usually this is carried out by payroll deductions. The contributory principle may be applied only to the individuals to be served by the plan or extended to simultaneous inclusion of other groups, such as employers who are directly concerned. Third, under compulsory schemes government assumes responsibility for proper and sound legislation. Clearly defined rights are conferred on all people to whom the law applies, and the duties of the various groups concerned are set forth. Type, scope and amount of services and other benefits are determined and the details of financing arranged. Furthermore government reserves the right of supervising operation of the schemes as to compliance with laws and statutes and efficiency of performance.

### Attitude Toward "Compulsory Health Insurance" in the United States

The American movement for compulsory health insurance against the risks of illness dates back to 1913, when the First American Conference on Social Insurance was held in Chicago under the auspices of the American Association for Labor Legislation. In 1915 the American Association for Labor Legislation drafted a tentative bill. This "Standard Bill" became the basis for repeated attempts to advance required programs beyond the conversational stage. In 1919, Governor Smith of New York State referred to health insurance in his annual message by pointing out:

"Nothing is so devastating in the life of the worker's family as sickness. The incapacity of the wage-earner because of illness is one of the underlying causes of poverty. Now the worker and his family bear this burden alone. The enactment of a Health Insurance Law which I strongly urge, will remedy this unfair condition. Moreover, it will result in greater precautions being taken to prevent illness and disease, and to eliminate the consequent waste to the State therefrom. It will lead to the adoption of wider measures of public health and hygiene, and it will operate to conserve human life. The large percentage of physical disability disclosed by the draft, shows how deeply concerned the State is in this matter. Proper provision also should be made for maternity insurance in the interest of posterity and of the race. Other countries are far ahead of us in this respect, and their experience has demonstrated the practical value and economic soundness of these principles."

However, steadily growing opposition united in a common front against "compulsory health insurance," such heterogeneous groups as commercial insurance and fraternal orders, the drug industry and drug distributors, capital and labor, organized medicine and Christian Science. The movement came to a deadlock at the turn of the twenties.

The next phase is characterized by quite a different approach. Intensive searching, analyzing and finding of facts on needs and resources in the field of medical care had a commanding influence on this development. Among a great number of investigations, two attracted the widest attention; the studies conducted by the Committee on the Costs of Medical Care during the years 1928-32, and the National Health Survey conducted by the U. S. Public Health Service during the winter of 1935-36. These studies accumulated a tremendous volume of data on the social and economic aspects of medicine. Yet, the practical application of these data proved to be extremely difficult because of the magnitude of the problem and the multitude of its implications.

The Committee on the Costs of Medical Care, when trying to formulate recommendations for its final report, split over two major issues, namely



group practice of medicine and group purchase of medical care. Still another split occurred when the question of choosing between compulsory and voluntary "health insurance" arose. Out of 50 members 11 recommended compulsory plans. Five other members disagreeing with the majority's preference for voluntary schemes, wanted at least experimentation with both methods. It was the findings of the National Health Survey that stimulated anew the efforts to adapt American medicine to the rapidly shifting social scheme.

A National Health Program, prepared by the "Technical Committee on Medical Health Care to the Interdepartmental Committee to Coordinate Health and Welfare Activities," was submitted to a National Health Conference, held at Washington in 1938. Of five recommendations "for meeting with reasonable adequacy existing deficiencies in the nation's health services" two referred to methods of protection against the financial burden and the economic insecurity which sickness creates for self-supporting persons. The report continued: "No conclusion has emerged more regularly from studies on sickness costs than this: The costs of sickness are burdensome more because they fall unexpectedly and unevenly than because they are large in the aggregate for the Nation, or, on the average, for the individual family. Except in those years when unemployment is widely prevalent, sickness is commonly the leading cause of social and economic insecurity. Without great increase in total national expenditure, the burdens of sickness costs can be greatly reduced through appropriate devices to distribute these costs among groups of people and over periods of time."

The "Technical Committee" reported that it could not find the answer to the Nation's problem in voluntary insurance efforts. It reached the conclusion "that government must assume larger responsibilities than it has carried in the past if it is to help self-supporting people meet the problems of medical costs." According to the committee, the goal may be reached through the use of taxation, or through insurance, or through a combination of the two, preferably on a statewide basis. Public medical services and health insurance were methods recommended to be used as alternatives or in combination. The states would choose, develop, and administer the program which best fits their special conditions. The Federal government would furnish aid and assistance to the states. On this basis the Technical Committee recommended Federal grants-in-aid toward "approved classes of expenditures" made by the states in carrying out a more general medical program. In addition the Committee recommended Federal action toward the development of disability compensation on the basis of insurance against loss of wages during sickness, commencing as follows: "Such a program should preserve a high degree of flexibility, in order to allow for individual initiative, and for geographical variations in economic conditions, medical facilities, and governmental organization. It should provide continuing and increased incentives to the development and maintenance of high standards of professional preparation and professional service; it should apportion costs and timing of payments so as to reduce the burdens of medical costs and to remove the economic barriers which now militate against the receipt of adequate care."

The President, in his message to Congress on January 23, 1939, summarized the objectives and meaning of a National Health Program as follows:

"The objective of a National Health Program is to make available to all parts of our country and for all groups of our people the scientific knowledge and skill at our command to prevent and care for sickness and disability; to safeguard mothers, infants and children, and to offset through social insurance the loss of earnings among workers who are temporarily or permanently disabled. . . . The essence of the program is Federal-State cooperation. Federal legislation necessarily precedes, for it indicates the assistance which may be made available to the States in a cooperative program for the nation's health."

Subsequently, on February 28, 1939, the Wagner Bill (S. 1620) was introduced in Congress: "a bill to provide for the general welfare by enabling the several states to make more adequate provision for public health, prevention and control of disease, maternal and child health services, construc-



tion and maintenance of needed hospitals and health centers, care of the sick, disability insurance, and training of personnel; to amend the Social Security Act; and for other purposes." A subcommittee of the Committee on Education and Labor, U. S. Senate, early in 1940, reported favorably on the general objectives of this bill, at the same time admitting that revisions were necessary.

Meanwhile the American Federation of Labor had reversed its former attitude and, in 1935, adopted a resolution "urging the enactment of socially constructive health insurance legislation." In 1940 the American Association for Social Security offered a revision of its "Standard Bill," first published in 1934.

One attitude taken by organized medicine is revealed in the action of the California State Medical Society in 1933, when it formally endorsed the principle of compulsory insurance against sickness. A special state committee prepared a "Health Service Insurance Act," the first and only bill drafted by a medical organization. Later, support of the bill was withdrawn.

The Social Security Act, as first planned, was to cover three subjects: unemployment, old age, and medical care. However, planned provisions dealing with risks arising out of ill-health were dropped after consultation with a committee of 12 physicians.

In February, 1935, the House of Delegates of the American Medical Association had passed a resolution reaffirming "its opposition to all forms of compulsory sickness insurance whether administered by the Federal Government, the Governments of the individual States or by an individual industry or similar body." The Social Security Act was passed without provisions for medical care.

In 1937, a committee of physicians, later taking the name "Committee of Physicians for the Improvement of Medical Care, Inc." came out with "Principles and Proposals" in an effort to make constructive recommendations. In concluding a list of proposals the committee stated "health insurance alone does not offer a satisfactory solution on the basis of the principles and proposals enunciated above."

In 1938 the American Medical Association considered the National Health Program at an emergency meeting held at Chicago. The president, in his address, pointed out: "the American Medical Association never has opposed the principle of insurance" and added: "It is not the principle of insurance that is opposed by American medicine. The principle which we do oppose is political administration and manipulation of the insurance organization, devotion of a considerable portion of the funds thus derived to the payment of a great number of employees not directly concerned with the service but intimately concerned with the maintenance of a political organization, and expansion of such organizations to wield greater and greater power in the affairs of the nation."

The American Medical Association approved not only the "principle of hospital insurance" and "voluntary indemnity insurance." They endorsed required insurance against loss of wages during sickness and expansion of workmen's compensation.

But they were "not willing to foster any system of compulsory health insurance." The American Medical Association was "... convinced that it (compulsory health insurance) is a complicated, bureaucratic system which has no place in a democratic state. It would undoubtedly set up a far-reaching tax system with great increase in the cost of government. That it would lend itself to political control and manipulation there is no doubt."

If the development were to take the course presupposed by the American Medical Association, compulsory program certainly would be most defective. Whether the evils feared by the American Medical Association are necessarily inherent in such a program is a question which cannot be brought to a decision without full knowledge of all the details of policy and procedure to be adopted. As the "Committee of Physicians for the Improvement of Medical Care" puts it: "Whether we are favorably inclined to the principle of compulsory health insurance, or not, it is the part of wisdom to establish in advance the general principles which should govern such projects."

## Principles and Trend of Development of "Compulsory Sickness Insurance" in Foreign Countries

*Reasons for the Development of Required Programs.*—Abroad one country after the other proceeded to establish sickness insurance plans. The factors determining the choice of compulsory sickness insurance were similar in many countries. They were stated to be the inadequacy of individual savings, public assistance, and voluntary health insurance. It was noted in many instances that the life's savings of an average family were wiped out by one serious illness, one major operation, one long hospitalization, one prolonged series of treatments. It was found that tax-supported medical care, in the form of public assistance, was not feasible for many self-supporting people. It was found that voluntary health insurance, while feasible for people in the middle income groups, could not reach the large self-supporting population groups within the lower income brackets.

*The Purpose of Compulsory Sickness Insurance Plans Abroad Has Been Three-fold*—(1) compensation for loss of earnings due to illness, non-industrial injury and maternity; (2) provision of medical care as necessary to restore good health; (3) preventive medical services for well persons. In its early days the function of sickness insurance was centered on prevention of the economic consequences of ill-health. In the first phase of evolution most of the plans gave preference to the payment of "cash benefits" so as to compensate wage-earners for loss of wages due to disabling illness. In the second phase of evolution provision of medical services of various types was increasingly emphasized so as to prevent sickness from progressing into the chronic or incurable stage. In fact, in some countries sickness insurance plans became primarily a mechanism for the restoration and conservation of health by "benefits in kind." Provisions for early diagnosis and thorough treatment in an early stage took the place of provisions for disability compensation. In the third phase of development, more attention was given to preventive medicine including maternity care. The significance of this marked change in concept must be interpreted in relation to the American situation. Medical care in many foreign countries was organized on a curative basis with a large number of autonomous administrations which were difficult to adopt to the development of preventive services. A modern medical program should provide for a complete integration of preventive and curative services. Sickness insurance was designed to meet primarily needs of such sick people as could be covered by the program. Compulsory sickness insurance constituted one avenue to the goal of a national health program; being a method, rather than a panacea, it was always combined with other methods, such as voluntary insurance and tax support according to the needs of the various economic and occupational groups.

*Coverage.*—There were, and still are, wide variations in scope of coverage in various countries—according to the prevailing needs.



However, there are certain principles and trends common to many foreign programs. In broad terms eligibility for compulsory sickness insurance may be determined in either of three ways or in combination of all three: (1) by income regardless of type or occupation; (2) by type of occupation regardless of income; (3) by type of employment, such as industry, business, agriculture, domestic service. At their beginning, compulsory schemes were applied primarily to specified groups of wage-earners such as industrial workers. Later the prevailing philosophy was to extend the programs to many other occupational groups including office employees, white collar workers and other employees receiving salaries.

Finally the principle was not only applied to industry but increasingly also to commerce, agriculture, and domestic service, with a definite trend toward equality of service for all groups covered.

In 1939, the British law required insurance from all workers, and from those white collar workers who earned less than 250 pounds per year. Similar are the provisions of the Australian scheme. The French law is applied to all employed workers subject to income limits.

In their early phases many programs served "wage-earners" only. If family dependents were included they were usually provided with maternity services first.

In other instances provisions for family dependents comprise at least a selected number of fundamental medical services. In those countries where family dependents were covered along with the wage-earners a definite trend developed toward making such service more and more complete. The omission of family dependents from coverage has greatly reduced the value of the British system and those designed along the British precedent.

In a number of foreign countries the following services are made available to a varying degree: physicians' care at home, office and hospital, including services by general practitioners and certain specialists; maternity services, including prenatal, obstetrical and post-natal care; hospitalization, including care at general and special hospitals, and at convalescent homes; supply of drugs subject to certain restrictions; supply of certain appliances contingent upon special requirements. In addition, dental services often are partially or completely included.

There are instances of rather all-inclusive services and most of the schemes provide for hospital care. However, it must be emphasized that in certain countries the type, scope and amount of medical care, provided under compulsory sickness insurance, fall short of modern standards. In fact, the British government did not follow the inauguration of its health insurance program with adjustments from time to time to the progress in scientific medicine. Today, just as in 1911, the "standard medical services" are restricted to such "as can properly be undertaken by general practitioners of ordinary competence and skill," and hospitalization must be purchased by supplementary voluntary plans or, if



that is impossible, obtained through public assistance. It is significant that the British Medical Association, representing the private practitioners, repeatedly and strongly advocated the removal of existing defects by extension and improvement of the present scheme rather than by its abolition. A report of the British Medical Association, in 1938, reiterated recommendations made before (Proposals for a General Medical Service for the Nation), and urged broad "extension and amplification" of the scheme. A series of "basic principles" was made public, among them a recommendation "that consultants and specialists, laboratory services, and all necessary auxiliary services, together with institutional provision, when required, should be available for the individual patient, normally through the agency of the family doctor."

*Distribution of Medical Care.*—The private practice of medicine as contrasted to a salaried civil service system has been maintained as a rule. Physicians, engaged in private practice, are free to attend private patients only. They are also free to offer their services for both patients who pay directly and patients for whom the administration of the insurance plans foots the bill. In fact, in most of the countries private physicians render service simultaneously to both groups. Contrary to the general impression, no country abolished private practice. Accordingly the principle of free choice of physicians has been preserved. A person eligible for insurance service was allowed to choose his physician from among all those duly admitted to this type of practice.

*Remuneration of Physicians and Allied Groups.*—Physicians and the allied professions are compensated for service rendered under compulsory sickness insurance under three plans: (1) under the "per capita system" the physician is paid a flat rate per year per person on his list; (2) under the case system fixed fees are paid per case of illness attended; (3) under the unit system each service given is paid for on the basis of a special fee schedule. There are also many combinations and variations of these three basic procedures in use.

Examples of each system are: Great Britain for "per capita system;" German republic for "case system;" France for "unit system."

The method of physician reimbursement is of utmost importance. Careful judgment is necessary in selecting a procedure which does justice to both physicians and patients. The experience gained in foreign countries reveals certain points of general significance. Remuneration on the basis of a standardized flat rate per eligible person, when proposed, usually was opposed by the organizations of the medical profession.

Inevitably the adoption of the fee-for-service system led to the establishment of control methods designed to clear up marked differences in individual bills and to balance between available money and charges of physicians.

A number of small groups of English counties originally adopted the method of payment by fee for each unit of service rendered.

After 1914 this system was not retained in any of the areas except Manchester and the neighboring district of Salford. The Salford and Manchester doctors abandoned the method at the end of 1926 and 1927 respectively, after 15 and 16 years' experience with it.

"The general sentiment relative to the change to capitation seems to be a profound relief that bickering over accounts is ended and that bookkeeping is transferred to the Insurance Committee, which pays the doctor according to a uniform system that plays no favorites."<sup>12</sup>

The French system of health insurance is particularly interesting because it is in marked contrast to most others. It was what the profession wanted. But when the physicians had it they became increasingly dubious that it was the system they really wanted. The French physician bills his patient as he chooses and collects what he can. The patient pays his own bill and is reimbursed by his insurance organization up to a certain percentage of the agreed standard rates for specified services.

The greater difference between the fees charged by physicians and the reimbursement payable under the medical benefits brought about a considerable nullification of the insurance itself.

"In France the maintenance of the fee-for-service system with all its implications has led to the introduction of a number of control measures."

"Medical supervision, investigation, hearings, etc., bureaucracy, conflicts of opinion on medical issues, conflicts of judgment on costs—these and other difficulties have not been avoided by the French system of remunerating the doctor. On the contrary, by the victory of dictating the system of remuneration and assuring the patient complete free choice of doctor, the French doctors achieved strongest limitation of fees, a complex and cumbersome fee schedule, necessity for close administrative supervision, conflicts with insurance authorities, and a considerable loss in public esteem."<sup>13</sup>

*Quality of Medical Care.*—Quality of medical care cannot be measured and appraised in terms of statistical data. Factors of decisive importance to the maintenance of high standards in medical care are first, caliber of physicians, dentists, pharmacists, nurses and all other related groups; second, type, amount and accessibility of services offered; and third, the extent to which these services are used. An inadequate volume of services cannot be satisfactorily balanced by the availability of a sufficient number of well-trained personnel. Provision for a sufficient quantity of service cannot offset the lack of well-trained professional people. As conditions vary so widely in the various countries no brief summary of the relevant facts can be made here. A more detailed study would have to take into account all the points mentioned before.

<sup>12</sup> In the report of the Royal Commission on National Health Insurance, 1924, Appendix C, p. 9, it was mentioned that some of the Insurance Committees wished to put the Manchester system in effect but the opposition of the medical profession was so great that capitation was retained.

<sup>13</sup> Falk, I. S., *Security Against Sickness*, 1936, pp. 235-236.

*Scope and Extent of Compensation for Disability.*—A fundamental change has taken place in the concept of the purpose and functions of compulsory sickness insurance. Fifty years ago there was some justification in believing that "the dominant motive in the establishment of every system of health insurance is the relief of poverty, not the preservation of public health." Ample experience during the past half century bolsters the conviction that the functions of compulsory sickness insurance are much wider and quite different in scope.

Experience also led to the conviction that a liberal provision for medical care was the best way to prevent dependency and reduce the need for extensive compensation for loss of earnings. There are wide variations in the rates of cash benefits to compensate the insured person for wages lost due to disabling illness, injury or maternity. In most of the countries at least half of the wages is taken as the basis of cash benefits, and in some countries two-thirds.

In a considerable number of foreign countries certain trends have developed. First, medical care was ranked ahead of cash benefits. In many countries the expenditure for medical care rose proportionately more than that for cash benefits. In 1933 the ratio of expenses for medical care to expenses for cash benefits was approximately 4:1 in Denmark, 3:1 in Poland, 3:2 in Germany and 7:10 in Great Britain. In 1935 the respective ratio in France was 5:2 for non-agricultural workers and 3:1 for agricultural workers, maternity payment excluded.

Second, compensation increasingly was paid in a certain proportion to the wages earned rather than as a flat rate, so as to help the insured people in maintaining their usual standard of living.

Third, a steady tendency developed towards the application of a sliding scale of compensation so as to give reasonable support to large families and people in the lowest income groups rather than to single individuals and insured people with higher income.

*Administration*—of the foreign sickness insurance schemes usually has been placed under the authority of autonomous self-governing bodies. The sickness insurance system was separated both financially and administratively from existing public health or welfare agencies. The democratic principle and concept of self-government, while chosen for governing the pattern of organization and administration, presented difficulties in practice. So far, no magic formula has been found to solve all the problems in a way which suited everyone.

The principle of self-government was applied to all concerned rather than to only a few groups. In the first phase of development, insurance schemes in many countries were administered by laymen only. It is a poor policy to refuse those who render the services, primarily the physicians and allied professions, an equal opportunity for administrative responsibility. This omission has become a source of persistent unrest and strain under certain foreign plans. It has led to the deep-rooted conviction that compulsory sickness insurance inevitably had the implication of lay control



over professional services. In the second phase of development—rather late—the medical and related professions were authorized to take an active part in the administration. Local administration of medical service either was divorced from management of cash payments (Great Britain) or the program as a whole was managed by a self-governing body composed of representatives of the insured people, employers, medical and allied professions, and public health agencies. Central administration was placed either in Departments of Labor (most of the countries) or in Departments of Health (Great Britain, excluding Northern Ireland); often—but not always—medical officers were in charge of a division of these departments.

*Financing and Costs.*—In financing compulsory sickness insurance the contributory principle has been predominant and tax-support has remained a minor feature. The programs have been financed primarily by regular contributions both from the people covered by the programs and the employers of insured people.

The proportionate share of contributions made by employers and employees has been established in different ways. In broad terms there are countries, such as Great Britain and France, where the employers match the contributions of their employees on a 50:50 basis. In other countries the major responsibility was placed on the insured themselves, who often paid two-thirds of the total contributions. This, of course, gives only a rough picture of the situation. Experience has demonstrated the necessity of special regulations which deserve careful consideration. In industries where there is an enhanced danger from occupational diseases, the employer's share should exceed that of the wage-earner, and people in the lowest income group should be privileged by the payment of only nominal contributions.

Many countries have provided for government subsidies derived from tax revenues to supplement the contributions of employer and employee. Such appropriations were either earmarked for administrative purposes or special services, or they were made without definite stipulations. Since 1926, the English government has borne one-seventh of the total health insurance budget in the case of male and one-fifth in the case of female members. In the neighborhood of 15 percent of the total income of the health insurance scheme comes from these grants-in-aid. In other instances the government subsidy amounted to more than this (Denmark) or only to a small fraction of the budget of compulsory sickness insurance. Due to the wide variations in coverage and functions of the various schemes no general comment can be made regarding the part of the payroll required to pay the contributions of both employers and employees. There is, however, evidence that a total of 5-6 percent of the payroll has been sufficient to defray the costs of rather inclusive provisions for medical care and reasonable disability compensation.

The utmost care must be taken in drawing conclusions from foreign cost figures. Any comparison of rates or proportions is fallacious because of the tremendous variations and steady changes

in service, method of physicians' remuneration and population groups covered. In addition it is hardly possible to express foreign figures in terms of dollars because of the differences in purchasing value and the fluctuations in exchange. Any attempt to use financial data from foreign experience for plans to be designed in this country would result in confusion rather than enlightenment. If compulsory plans are to be considered in this country the detailed cost figures must be estimated. Of prime importance would be type, scope and amount of services and benefits to be included; methods of distributing medical care; method of physicians' compensation; type and income of groups to be covered; health status in the various communities and probable demand—to mention only a few basic factors.

### **Lessons from Foreign Experience—Strong and Weak Points**

The significance of foreign movements towards compulsory sickness insurance is revealed in the following principal trends:

1. There has been a steady trend towards replacing voluntary by compulsory programs—first, in Europe, later, in many other parts of the world.

2. The inalienable right to seek and expect a certain amount of security against illness has been firmly established for substantial groups, often the majority of the various peoples.

3. In adopting sickness insurance programs the governments in a steadily increasing number of countries turned from legislation for abatement of nuisances and prevention of certain communicable diseases to legislation concerned with social security. To the negative approach of forbidding, government added the positive approach of granting something, and substituted comprehensive planning for isolated procedures.

4. The various governments issued detailed laws which clearly defined the rights and the duties of the people; supervised the operation of the programs which were managed by self-governing bodies; and assisted the programs by sharing a part of the costs.

5. Because of the interdependence of illness and economic conditions the programs as a rule were inclusive in the sense that they provided for both medical care and compensation of wage loss.

6. Restoration and improvement of health, originally a by-product of the plans, has become a major objective. There has been developed a definite trend to rank compensation for disability second to provision for medical care.

7. Compulsory sickness insurance, originally designed for specific groups of wage-earners, has been expanded to include larger economic occupational sections of the populace, to cover family dependents along with the wage-earners, and also to serve people who joined voluntarily.

8. Scope and amount of medical care has been steadily increased in line with stronger emphasis laid on service rather than on payment of cash.

9. Distribution of medical care has been usually based on the precept of the private practice of medicine.

10. Quality of medical care has been increasingly emphasized, primarily by excluding from participation quacks and cult practitioners, and by improving the type and extent of services available.

11. Compensation for disability has remained an important feature of the programs although it has advanced proportionately on a smaller scale.

12. Administration of compulsory sickness insurance has been severed from some of its worst original features by the development of professional supervision of professional services and by the attempts to create efficient large-size administrative units.

13. The costs of the programs have been met primarily by contributions from both the insured and employers and on a small, although varying, scale by government subsidies.

14. In no country was compulsory sickness insurance designed to solve the problem of medical care for all groups of the population. Being a device for self-help by self-supporting people and a technique of dealing with the economic risks of illness it did not, and could not, make other methods superfluous. Voluntary insurance and tax-support still were employed for those for whom the contributory and compulsory principle was not feasible.

Experience has also shown that no human being has been able to present a formula which suits all.

It would be indefensible indeed if any State in this country imported and repeated the mistakes made abroad. Foreign experience can clearly demonstrate stumbling blocks and shortcomings which must and can be avoided. From the oldest law, the German, we can learn how detrimental it is if the medical profession is kept out from active participation in administering sickness insurance. The recently established French law shows the disadvantages of the indemnity and fee-for-service idea. The British experience illustrates that a plan with no provision for certain specialists' services, hospitalization, and services to family dependents arouses more and more criticism from the physicians themselves as well as the insured persons. In addition, it reveals the deficiencies inherent in the existence of a great number and variety of administrative units. Finally, all these programs illustrate what happens if schemes based on the insurance principle are not from the outset coordinated and integrated with all other community health and welfare programs, both voluntary and public.

### **Workmen's Compensation in the United States**

Workmen's compensation is a method of applying the idea of compulsory insurance against two specific risks to health, namely industrial accidents and occupational diseases. Hence, it is compulsory health insurance in essence although not explicitly in form. The development of workmen's compensation in this country gives insight into many problems of primary importance to compulsory sickness insurance.



Between 1886 and 1917<sup>14</sup> nearly every important industrial state in this country modified or abrogated one or more of the common law defenses, which protected the employer against actions for damages growing out of accidents to his employees, and introduced the system of "Legal liability of the employer." This led to employers being involved in a mass of litigation and they found insurance companies ready to assume the risk and profit.

How effective they were in fulfilling this objection is shown by J. R. Commons' description<sup>15</sup> of what took place in Wisconsin:

"Employers in Wisconsin paid \$1,225,000 to liability insurance companies in 1911; scarcely \$300,000 of it reached the pockets of the employees or their dependents. Ten thousand industrial accidents occur in Wisconsin every year; 100 of these are fatal; the others cause disability of seven days or more. Scarcely 10 percent of the injured received any share of the \$300,000.

The defects of liability insurance became so flagrant that employers as well as employees demanded that the United States follow the example of Europe by substituting the principle of "occupational risk" for that of "employer's liability."

Subsequent to the Federal Employees Compensation Act of 1909 one state after the other adopted so-called Workmen's Compensation Acts. In 1939, 47 states<sup>16</sup> had such laws in operation. Workmen's compensation still persists in two-thirds of these states on a voluntary basis exclusively.

While all the laws actually in operation cover accidental injury, only about half of them include occupational diseases on a carrying scale.

A provision for medical care in the early laws was meagre. A few observers in the first stages of workmen's compensation recognized that a wrong start had been made in placing all emphasis on cash compensation to the neglect of medical services.

Within recent years this tendency to expend money on restoration of health has possibly proceeded at an even more rapid rate than the liberalization of benefit for financial care. Ethelbert Stewart,<sup>17</sup> Commissioner of the United States Bureau of Labor Statistics, stated in April, 1931, that "Through the workmen's compensation commissions of the United States, we pay the physicians and hospitals \$72,000,000 annually." He<sup>18</sup> comments further on the relative increase of medical and compensation payments:

"When we began the administration of workmen's compensation laws, the relation of doctors' bills to compensation, or to the amount that the injured workman got, was 5 percent. Today it is 35 percent and in temporary cases it ranges from 50 to 75 percent of the amount that the injured workman gets."

<sup>14</sup> Medical Relations under the Workmen's Compensation, Revised 1935 Report of the American Medical Association, p. 10.

<sup>15</sup> Commons, J. R., Industrial Commission of Wisconsin, Its Origin and Methods, Survey, Jan. 4, 1913, p. 3.

<sup>16</sup> Progress of State Insurance Funds, Bulletin No. 30, 1939, U. S. Dept. of Labor.

<sup>17</sup> Stewart, Ethelbert: Bulletin 526, U. S. Bureau of Labor Statistics, April 1931, pp. 31 and 74, see p. 97 for actual figures.

<sup>18</sup> Stewart, Ethelbert: Loc. cit.

In New York State for the year 1931<sup>19</sup> medical benefits computed as a third of the total amounted to \$17,621,851 and cash compensation amounted to \$35,243,703. This figure does not include the disbursements of self-insurers.

The State of New York has an Insurance Fund<sup>20</sup> which began operation on July 1, 1914, and is a competitive carrier. During 1938 in New York State approximately three million employees were covered and more than forty thousand employers paid premiums. In 1937 it wrote workmen's compensation premiums totaling \$22,388,366. If written at rating board rates, these premiums would have amounted to \$26,844,564. This was 31 percent of all such premiums written in the State. The fund pays its own administrative expenses, and like all other carriers is assessed to cover the State Labor Department's expenses in administering the Compensation Act. In 1937 the fund's administrative expenses were 16.7 of earned premiums, but figured on the basis of rating board premium rates, this expense ratio was only 13.9 percent. These expenses include funds for extensive safety programs. Premiums are generally 25 percent below the rates charged by private carriers.

### Summary of Legislative Proposals for Compulsory Health Insurance in the United States

**Federal Bills.**—On the Federal level two bills must be mentioned.

*The Wagner Bill* (S. 1620): Introduced in Congress on February 28, 1939, provides under Title XIII Federal grants-in-aid to the states which set up programs for general medical care. No specification is made as to the type of program. The sums authorized under this title are to be "used for making payments to states which have submitted and had approved by the Social Security Board, State plans for extending and improving medical care." Federal grants-in-aid under Title XIII may range from 50 to 16⅔ percent. This has been interpreted to include compulsory health insurance schemes if chosen by the states. Furthermore, Title XIV calls for grants to states for temporary disability compensation.

*The Capper Bill* (S. 658): Introduced on January 16, 1939, deals specifically with compulsory sickness insurance. It proposes to set up a Federal insurance board for the approval of State systems of compulsory health insurance. All persons engaged in manual labor were to be included in the coverage of such insurance, and all persons employed at other than manual labor and receiving less than \$60 a week. Dependents of employees were to be entitled to medical benefits. Cash benefits to the disabled employee, due after a waiting period of between three and five days, were to be based on 50 percent of the employee's full-time wages with a minimum of \$15 and a maximum of \$25 per week, with additional increases for dependents. Aggregate contributions to the fund were to be 6 percent of the total of all wages paid insured employees. Such contributions were to be paid in shares by the employee, the employer and the state. Voluntary enrollment was included in the provisions of this bill. A director of health insurance as well as an advisory council was provided for at the Federal level in addition to the Federal Health Insurance Board. Allocation of Federal funds to approved state insurance plans were to be subject to the Federal Health Insurance Board's approval. An appropriation of \$200 million per year for distribution to states maintaining adequate systems of health insurance was provided.

<sup>19</sup> Medical Relations under Workmen's Compensation Report, Revised 1935, American Medical Association, p. 98.

<sup>20</sup> Progress of State Insurance Fund under Workmen's Compensation, U. S. Department of Labor Bulletin No. 30, 1939, pp. 39 and 40.



*State Bills.*—By 1917 compulsory health insurance bills were introduced and killed in 12 states. Since then many bills have been introduced in a considerable number of states. In recent years four bills have attracted wide attention:

1. *The Epstein Bill*: A model state bill for health insurance, advocated by the American Association for Social Security. The drafting was done principally by Professor Herman A. Gray, of New York University Law School. The bill is in process of revision.

2. *The New York State Wagner Bill*: By Assemblyman Robert F. Wagner, Jr., was first introduced in 1938 and reintroduced in revised form in 1939. The 1940 version embodied drastic changes.

3. *The California Bill*: Drawn up by the Governor's Committee on Health Insurance, California Assembly No. 1272, as amended April 14, 1939.

4. *The Wisconsin Bill*: Assembly Bill No. 807A, introduced by Arthur Bie-miller first in 1937 and again in 1939 with slight revisions.

The elements common to these bills are: application to the whole state; coverage of economic groups within definite income brackets; inclusion of family dependents in scope of service; clause for voluntary membership; right to services including physicians' care by both general practitioners and specialists; hospital care, limited dental care and certain other services; participation in the program open to all physicians; free choice of physician and financing primarily by contributions from both employers and employees and assisted by state government allocations (except Wisconsin Bill).

### **Problems of Compulsory Health Insurance with Special Reference to New York State**

It is well known that the needs and resources of our 48 states vary tremendously. There are differences in size and composition of the population, socio-economic conditions, health status and educational levels. These factors indicate the inadvisability of planning a uniform nation-wide medical care program without taking into account these important differences. While it is natural, rational and economical to prefer overall planning of medical care it is equally imperative to differentiate between individual methods of financing state programs.

Compulsory health insurance has proved to be primarily feasible for industrialized areas with large and stable groups of employees working for salaries or wages, and a densely settled population. The problem in the rural areas is so loaded with difficulties that it would be a waste of effort to consider health insurance for residents of such areas as long as there is no established program in the industrial areas. In a state in which a substantial part of the population consists of independent farmers and persons employed in agriculture, support of compulsory health insurance by contributions would be insufficient, and considerable allocations from taxation would be needed.

On the basis of these facts, if compulsory health insurance is considered, the national approach is preferable. If only some of the industrial states take the lead, while all others refrain from adopting a medical care program of any kind, a rather awkward situation may arise. If an individual state with a substantial industrial population adopts either a compulsory health insurance scheme, or a tax-supported program on a larger scale than before, industry residing in such a state may be put in a less favorable competitive position than industries in other states with less finan-



cial obligation. This might lead to the moving of industry from a state with a definite medical care program to a state without any program. Furthermore, a state with a successfully working compulsory health insurance plan may face a break-down of its program when business slumps, wages fall, and unemployment increases. Such a period of economic depression is precisely the time at which industry and labor are least able to contribute to an insurance scheme. There ought to be a reserve fund capable of meeting increased demands in times when there are fewer revenues. If the group covered by compulsory health insurance is small and unable to make the necessary prepayments for rainy days, and if the total population of a state cannot readily raise taxes sufficient to make up the difference, then a system standing alone in an individual state has to bear the brunt of the first shock—and may fall.

*Coverage.*—There are many difficult problems involved in the classification of groups to be covered by compulsory health insurance.

There is no divergence of opinion that any medical care program confined to "wage-earner" and excluding his family dependents is contrary to American concepts. Any compulsory health insurance plan in this country should from the very beginning be a family program rather than a plan for the individual.

However, two points must be clarified. First, the family members must be dependent on the insured wage-earner and—as a rule—live in the household of the insured. Second, the term "family dependent" must be qualified. Husbands, wives, and children (including stepchildren and adopted children) of personally insured people should be included if and when they are dependent on the insured and live in his household. Whether grandchildren, parents, brothers and sisters, and grandparents can be granted the same privilege, in the order listed, remains a question of costs and should be left to the discretion of such administrations as are financially able to extend coverage to this extent.

The section of the population to be included in any proposed compulsory scheme may be determined on the basis of income, type of occupation, or kind of establishment in which the respective persons are employed. Combination of these ways of classification seems to promise the best and most economical solution. I. S. Falk, in outlining the basic principles for an American program points out that coverage "should embrace all medical care and loss of wages on account of sickness bringing variable costs which are burdensome and cannot be budgeted on an individual or family basis."

But how can these economic groups be determined? Where the demarcation line is drawn between those for whom medical costs are burdensome if paid on an individual basis and those for whom there is not a problem, is of far-reaching importance. One school of thought assumes that a family income exceeding \$5,000 a year usually gives security against the economic risks of illness. Families earning less than \$5,000 but more than \$3,000 may have their solvency endangered by the costs of expensive or protracted treat-

ment but may be considered able to meet immediate and urgent medical needs out of their own resources. Families earning less than \$3,000 annually may be regarded as those primarily needing programs which allow them to budget their expenditures for sickness, injury and maternity.

Restriction of compulsory health insurance to low income groups—say up to \$1,500—would endanger the efficiency of the plan and nullify all efforts to remunerate private physicians satisfactorily. The more the risks are spread over a large cross-section of the population, representing various occupational and economic groups, the more can the type, scope and amount of services be increased, operating expenses per eligible person decreased, and rate of contributions kept at a minimum. Legislative proposals in this country vary widely in their choice of coverage.

*Scope of Any Proposed Compulsory Health Insurance Program.*—All facts known about needs seem to point to the conclusion that, in any future American program, provision for medical care should have the dominant place, and provisions to meet the economic risks of high-cost illnesses must be particularly emphasized. However, disability insurance must not be barred from the program as a whole.

The proof of disability, namely certification of inability to work by reason of illness or injury, has been one of the most troublesome problems for foreign schemes. The only expert competent to certify is the physician. However, many physicians in private practice fear this job involves too many conflicts. There is furthermore the human desire to “get something back,” in return for payments made, which may lead to abuse of the provisions for cash benefits.

*Scope and Amount of Medical Care.*—In determining scope and amount of medical care under proposed compulsory health insurance plans the alternatives are an all-inclusive versus a limited program, and unrestricted access to all available medical services versus approval of specified services. The choice depends on the financial implications to the participants, namely, employer, employee and the State. Irrespective of any financial considerations one point must be emphasized: A program without provision for such services as are especially costly would miss its main function. In other words, it is services by specialists as well as hospitalization which must be an integral part of a program, in addition to general practitioners' services, clinical laboratory and roentgenological services. “Necessary” drugs and certain medical and surgical appliances should be provided subject to certain restrictions, and dental care, strictly defined as to type and extent, also should be included. Ultimately the problem revolves around the costs of such a program to all concerned.

*Organization of Physicians' Services.*—If under any compulsory health insurance proposal, people are required to budget for their sickness costs then there is a need for assuring that care will be given by competent men. The great variety of professions engaged in the art of healing makes it hard to find a proper and just working definition of competency. The situation is difficult because of



the variety of groups concerned. It is intricate because legally acknowledged healing art professions may base their claim for participation in a proposed program on their legal status. This problem should be settled in principle by legislative fiat and not by administrative regulation. Professional services for diagnosis and treatment under a proposed program should be given only by licensed physicians and dentists. Non-physicians should not be permitted independent insurance practice with the exception of optometrists for specified services. All other groups, if licensed, should be admitted to the furnishing of services either on the prescription of a licensed physician, or in cases of emergency. Cultists should be excluded.

The issue is not only distribution of medical care—it is distribution of good medical care by emphasizing the central rôle of the private practitioner of medicine.

*Remuneration of Physicians.*—Adequate compensation of professional services is paramount. Low pay cannot buy good service. The decision on the method of physicians' remuneration may go in one of three ways or use a combination of two or more of these. Under the fee-for-service system the individual physician is paid for each item of service rendered. Under the per capita system a flat rate per year, or parts of a year, is paid to the physician in accordance with the number of people eligible for his service and regardless of the frequency of visitation. Under the "case system" a fixed fee is paid to the physician on the basis of the number of persons attended, irrespective of the number of services rendered.

These three methods are mostly used in combination and have been tried out in many countries. The salary system has been seldom used to pay insurance practitioners. It has been used primarily for medical officers employed in the administration of the program. Often full-time salaried physicians on the staff of voluntary or public hospitals were responsible for furnishing medical or surgical services during a stay at a hospital, and payment for such services was made by the insurance administration.

Under any proposed health insurance plan the methods for remunerating the physicians—and allied professions—should be outlined without specifying the details. The administration of the plan should be authorized to select the appropriate method, scale and procedure of remuneration in close collaboration with the representatives of the medical profession.

The people covered by a medical care program, the participating physicians and hospitals, and the administrative bodies—all want the individual patient to receive the best possible care. As the budget may be limited excessive demands on the part of the patients and a tendency toward wasteful experimentation on the part of the physicians or hospitals must be avoided. This necessity is stronger if patients have completely free choice of physicians and hospitals, and physicians complete freedom of treatment and prescription. Among the patients who are insured some may be inclined to want all possible kinds of treatment irrespective of the costs.



In any proposed compulsory health insurance program consideration should be given to the following principles: First, treatment and prescription must be both adequate and economical; second, standards must be formulated in cooperation between the medical profession and the administration with regard to what constitutes adequate and economical medical treatment and prescription; third, a checking system should be established for securing adequate and economical treatment, adequate and economical prescription, proper certification.

Who should do the supervisory work? It is a deep-rooted opinion that laybodies might take over this task, including the administration of medical care. Lay control of medical care is so much inferior to professional supervision that from the viewpoint of efficiency, not to mention all the other arguments, there is only one answer to the question. The activities of physicians participating in health insurance practice under any proposed program should be supervised by medical supervisors. These medical supervisors should not depend for livelihood on either the organized or competitive practice of medicine. They should be full-time salaried officers. Medical supervisors should be licensed physicians, taken from the ranks of the practising doctors, and have at least five years' experience in active practice. They should be appointed with the advice and consent of the local medical organization.

*Estimate of Potential Costs and Income under Various Proposals.*—Many factors of utmost importance enter into any consideration of the probable costs of any proposed compulsory health insurance plan.

First the factor of need: The amount of medical care hitherto received by various income groups is no sufficient basis for estimating costs of proposed programs. The volume of medical care received is not ordinarily commensurate with the amount of need regardless of how we may define need. The extent of service given, while showing the quantitative side, does not disclose the quality of care received.

In determining the need for medical care in a given area many elements need to be considered. The main factors involved are:

1. Density, sex and age distribution of the population;
2. Prevailing occupation;
3. Economic conditions in general;
4. Educational level including habits and customs;
5. Type, frequency, and severity of illness, injury, defects;
6. Status of public health and welfare activities;
7. Status of voluntary health and welfare activities;
8. Financial resources of the area with regard to ability to supply institutional facilities and services by professional personnel;
9. Financial resources of the people in various income groups, with regard to ability to purchase medical care;
10. Transportation facilities.

Second, the factor of demand: Need is not identical with the demand for medical care. There may be a definite need, yet little demand because a lack of understanding. There may be a strong demand previously not observed, because people are eager to avail themselves of services hitherto not accessible at favorable terms. Variations in demand—just as variations in need—naturally produce quite different utilization of facilities and a considerable range in costs. Whether increasing demand because of increased availability of professional services necessarily spells abuse is open to wide interpretation. One may well argue that treatment of early cases, minor ailments and borderline conditions is indispensable to any proposed program which has for its objective prevention of complications and chronic stages of illness.

If any proposed compulsory health insurance program is designed to provide good medical care then the demand may increase, at least during the first years of operation, when many a patient may seek advice, examination or treatment previously deferred.

Third, the factor of the scope of program: It is obvious that a program conducted on a limited scale with respect to professional services involves lower costs than an all-inclusive program operated without any restrictions.

Fourth, the factor of organization: The methods adopted for distributing medical services and organizing disability insurance under any proposed program may have profound effects on the ultimate costs of medical care as well as the extent of cash benefits.

According to the Commission on Economic Security and the Inter-departmental Committee to Coordinate Health and Welfare Activities "... a comprehensive system of health insurance nationally developed would call for total funds equal to four and a half percent of income of the covered population" and "... temporary disability compensation . . . would involve a cost of approximately one percent of wages." These figures seem to conform roughly with the experience abroad.

The first figure, for health insurance, is based on numerous studies of actual family expenditures for medical care. It was found that in general the average proportion of family expenditures spent for medical care is "surprisingly constant whatever the income or type of community."

The second figure, for disability compensation, is based on the assumption "that the proposed insurance system is to cover all wage-earners and salaried workers with a seven day waiting period, 26 week benefit period, a qualification provision having the same degree of strictness as the eligibility requirements of the British system and a benefit formula essentially the same as used in unemployment compensation."

If we apply these estimates to proposals for New York State the cost and potential coverage is revealed in the following:

The income necessary to meet these expenses, on the basis of the Assembly Bill, Introductory Number 2726, introduced in 1939

by Robert F. Wagner, Jr., in the New York State Assembly, would total \$162,760,668. The employee would contribute over 59 million, the employer over 70 million, and the State 32½ million, as shown in the following table.

#### EXPECTED INCOME OF A STATE HEALTH INSURANCE FUND

Based on 1937 Wage Income Distribution Data Prepared by the Federal Social Security Board and Calculated by Applying the Premium Rates Proposed in the 1939 New York State Wagner Health Insurance Bill

	Total *	State	Employer	Employee
Total.....	\$162,760,668 05	\$32,552,133 61	\$70,415,351 99	\$59,793,182 45
Under \$1,000.....	51,402,953 90	10,280,590 78	30,841,772 34	10,280,590 78
Under \$100.....	820,022 45	164,004 49	492,013 47	164,004 49
\$100-\$199.....	1,831,638 10	366,327 62	1,098,982 86	366,327 62
200- 299.....	2,678,099 25	535,619 85	1,606,859 55	535,619 85
300- 399.....	3,615,721 05	723,144 21	2,169,432 63	723,144 21
400- 499.....	4,504,039 30	900,807 86	2,702,423 58	900,807 86
500- 599.....	5,577,252 55	1,115,450 51	3,346,351 53	1,115,450 51
600- 699.....	6,696,842 90	1,339,368 58	4,018,105 74	1,339,368 58
700- 799.....	8,183,024 45	1,636,604 89	4,909,814 67	1,636,604 89
800- 899.....	8,476,724 50	1,695,344 90	5,086,034 70	1,695,344 90
900- 999.....	9,019,589 35	1,803,917 87	5,411,753 61	1,803,917 87
\$1,000-\$1,999.....	86,510,184 10	17,302,036 82	34,604,073 64	34,604,073 64
\$1,000-\$1,499.....	46,904,373 50	9,380,874 70	18,761,749 40	18,761,749 40
1,500- 1,999.....	39,605,810 60	7,921,162 12	15,842,324 24	15,842,324 24
\$2,000-\$2,499.....	24,847,530 05	4,969,506 01	4,969,506 01	14,908,518 03

\* According to the 1939 Wagner Bill, manual workers, all wage groups, are covered; non-manual workers with annual incomes of more than \$2,500 per year are not covered. Therefore, the estimates given above are probably somewhat lower than might be actually expected since a great many manual workers in industry have incomes of over \$2,500 a year and have not been included. The Social Security Wage income data available did not present a break-down of manual and non-manual wage income groups and therefore the 8 per cent of the wage earners in the income groups of \$2,500 and over were not included.

Under proposed Federal legislation the State would be reimbursed up to 50 percent of its expenditures (Wagner Bill) or 25 percent (Capper Bill) through Federal grants-in-aid.

Most of the proposed plans provide for contributions to the Insurance Fund by both employees and employers and additional allocations from the State. On the basis of the (1939) New York State Wagner Bill the distribution of financing would be as follows:<sup>21</sup>

Weekly income groups	Employee	Employer	State	Total
\$20 and less.....	1%	3%	1%	5%
\$20 and less than \$40.....	2%	2%	1%	5%
\$40 and over.....	3%	1%	1%	5%

The basic question involved is whether both employees and industry are able to contribute their share and whether the increase in the fiscal budget requires special measures.

<sup>21</sup> Schedule was revised in 1940 Wagner Bill.



## Employment and Payrolls <sup>22</sup>

Average Earnings of Employees in New York State in 1937.—Approximately 4,000,000 individual workers, an average of 3,094,587 workers in the highest pay period in each month of the year with total earnings of \$3,820,002,000, were reported by employers subject to the New York State Unemployment Insurance Law during 1937. According to these records, the average per capita wage in this group of insured workers for the year was \$955. This omits any consideration of wages earned by these persons outside of employment covered by the law. As compared with these figures, reports of the Bureau of Old Age Insurance of the Social Security Board show a total of 4,055,650 employees with total earnings of \$4,225,043,000 reported to the Federal authorities by New York State employers.

The per capita annual income of \$1,042 for those covered by old-age insurance compares with the \$955 indicated by the State's unemployment insurance records. This discrepancy of nearly \$100 in annual earnings is explained largely by difference in the coverage of the State and Federal laws and by the shifting of employees from insured to uninsured employment.

### Necessity for Coordination of Any Proposals for Compulsory Health Insurance with Existing Voluntary and Public Health and Welfare Activities

The historic development in this country has resulted in a large and diverse system of voluntary and public health and welfare activities. Public responsibility, originally centered on control of environmental sanitation and certain communicable diseases, has recently been increasingly assumed for medical care in the broadest sense. There has been a substantial increase in the use of taxation for the purpose of supporting public medical care and a rapid growth in the use of voluntary insurance particularly in the field of hospital care. In fact compulsory health insurance if adopted would not come in a vacuum.

It is imperative to utilize to the fullest extent existing facilities and services when adequate, and equally imperative to establish close relations between privately supported, tax-supported and insurance programs, both preventive and curative. The precise definition of functions to be fulfilled by any proposed health insurance plan is of paramount importance. Without exact demarcation of functions and scope it would be impossible to determine the proper place and potentialities of the various programs already in existence, and the genuine rôle of the proposed compulsory or voluntary health insurance plan.

There is a natural partnership between voluntary and public activities in the fields of health and welfare. Yet a bewildering variety of agencies, voluntary and public, are now conflicting with

<sup>22</sup> Placement and Unemployment Insurance Activities, Vol. 1, No. 4, April, 1939, p. 17.

each other with respect to eligibility requirements, services, organization and administration.

If compulsory health insurance is to be superimposed upon an uncoordinated system of existing health and welfare activities, then indeed, overlapping of functions, duplication of services and friction in administration would be perpetuated and extended. This dilemma is not inherent in any proposal for compulsory health insurance and can be avoided. Proposed legislation in this field should be premised upon the coordination of all community health programs.

On the face of it, the remedy seems simple. Unification of all agencies and allocation of all activities along definite lines, would serve expediency and economy better than isolation of agencies, each operating its own complete program without regard to activities conducted by others in the same field. In practice, even such a reasonable objective is difficult to achieve. Long established experience has demonstrated over and over again that proposals for cooperation between existing agencies and coordination are degraded to the status of mere slogans, unless there is over-all planning. This truth is no less valid because it is old.

The British experience should be a warning. In testifying before the British Royal Commission on Health Insurance the Society of the Medical Officers of Health pointed out that their service, "primarily concerned in the preservation of health generally, has from the beginning recognized the impossibility of adequately discharging its function in disassociation from measures for the restoration of health to individuals.

"It has become evident that the present system of National Health Insurance suffers great limitations in its possibility for promoting health, and that profound changes are required if the improvement in the health of the people is to continue to be aided and not impeded by it.

"The scheme . . . is, to a great extent, isolated from the other schemes of the State in operation and doing essentially similar work."

Lack of balance, continuity, and consistency of medical care has been a real problem for many foreign countries. If these developments had been foreseen at the beginning they might have been avoided. Instead, the proper moment for designing a broad program, namely, at the beginning, was missed and only partial compromises could be made.

Thomas Parran, Surgeon General of the United States Public Health Service, has pointed to this problem by saying:

"We cannot continue to think in terms of the separateness of public, private and voluntary efforts or of the separateness of preventive and curative efforts."

Any legislation, designed to make possible for all persons an equal opportunity for health and medical care of high quality, should require working agreements between all health and welfare agencies to insure success.

## Study 7

## SPECIAL HEALTH PROBLEMS

Existing governmental agencies are organized to provide health and medical care services to meet special health problems involved in the control of certain specific diseases and conditions for which accepted control methods have been established and the public health importance to the communities transcends the consideration of the economic status of the individual. Each of the special health problems has been a subject of study by the State Department of Health which has responsibility for their administration. The control programs have been developed jointly with the representatives of organized medicine. Legislative consideration and support has been given to permit practical application of the developments in these specialized fields of modern medical science. This summary constitutes a brief progress report covering recent developments in these fields, and in some instances specific recommendations for the future. The factors involved in chronic illness and infirmity have been given special emphasis in the Commission's studies relating to medical care in welfare districts and patients discharged from hospital wards.

**Pneumonia Control**

The recent advances in the methods of treating pneumonia through the use of specific serum and the more recent development of the chemo-therapeutic drug sulfapyridine, and its related compounds, have provided excellent means of combating the disease, which accounted for some 12,000 deaths in 1935 in New York State. These deaths greatly disturbed the economic stability of many families, since 40 percent of all the pneumonia deaths are of men and women in the economically most productive period of life—between the ages of 15 and 64 years.

The modern adequate treatment of pneumonia includes: hospitalization; laboratory diagnostic services (including sputum tests and blood concentration tests); physicians' services, often including consultation; specific serum; oxygen; x-ray; special drugs and nursing services.

Many individuals find the treatment of pneumonia too expensive for them to bear; a comprehensive study reveals that a reasonable average cost for a pneumonia case is about \$135, of which 42 percent went for hospitalization, 28 percent for physicians' services, 16 percent for serum therapy and 14 percent for other services.

The comprehensive pneumonia control program promoted by the State Department of Health, with the cooperation of the physicians of the State, during the past three years has been accompanied by a marked decline in the number of deaths in pneumonia during this period—although this disease still remains one of the principal causes of death.

Legislative appropriations for the production of the specific anti-pneumococcic serum by the laboratories of the State Department of Health and free distribution of such serum to practicing physi-



cians have resulted in a tremendous increase in the use of this modern scientific treatment throughout the State.

The current pneumonia program is characterized by two main efforts: a continuation of the basic program of the past four years, with the extension of the specific serum to approximately thirty types of pneumonia and the effective utilization of the new chemotherapeutic agent, sulfapyridine and related compounds.

### **Cancer Control**

Cancer is now the second cause of death and will probably continue to be important because of the increasing proportion of the older people in our population. Evidence indicates that the basis of cancer control must be the relatively lower case fatality obtained when cancer is recognized and treated in its early stages. The State Commissioner of Health has estimated that if the cure rates achieved among early cancer cases treated in the State Cancer Institute in Buffalo can be extended to all cancer cases in the State through the development of a coordinated system of adequately staffed therapeutic and diagnostic tumor and cancer clinics, there will be a saving of 5,000 lives each year in New York State.

The difficulty of early diagnosis, the lack of easy access to expert diagnostic and therapeutic facilities, a relatively high cost of these facilities, combined with the lack of natural spur of pain in the early stages of cancer—combine to explain the rarity of early diagnosis and treatment of this disease. The State of New York has since 1898 appropriated increasing sums for the laboratory and clinical study of cancer and the gradual development of therapeutic facilities in the State Institute for the Study of Malignant Diseases in Buffalo, New York. The increasing inadequacy of these facilities, despite the expansion at the Institute, resulted in a special study of the whole problem by a Legislative Cancer Commission.

This Cancer Commission submitted its final report in February, 1939, and many of its specific recommendations have been the basis, by legislative enactment, of the present Cancer Control Program. A new Division of Cancer Control has been established in the State Department of Health in Albany. Cancer has been made a reportable disease in Upstate New York to facilitate control measures, and great progress has been made in the extension of approved tumor clinics throughout the State, so that now no cancer patient will need to travel more than 50 miles to use the facilities of such clinics. These clinics are conducted by medical staffs of strategically located hospitals with the support of the organized medical profession which recognizes the advantages of keeping patients within the jurisdiction of the attending physician.

### **Syphilis Control**

Syphilis is a disease of great public health and economic importance, and modern science has developed methods for accurate diagnosis, specific treatment and precise methods for the prevention of the spread of this disease to others. Syphilis control can be attained by finding cases early and treating each patient until he

is no longer able to transmit the disease to others. If this could be done early in the course of every person's infection, no other measures would be necessary. If early treatment is deferred, while danger to others may cease, the devastating complications of the disease may have far-reaching effects upon the personal and economic well-being of the individual, the family and the State. The economic significance of this problem to the State is revealed in the estimate that 10 percent of the inmates of the State mental hospitals require such care because of late manifestations of syphilis.

The Bureau of Syphilis Control in the State Department of Health has developed a program devoted to the solution of these problems: through the stimulation of an early case-finding program; the development of approved local clinics and laboratory diagnostic facilities (with State aid provided in some instances): the distribution of specific anti-syphilitic drugs to physicians, clinics and hospitals; and, the promotion of legislation designed to discover and treat syphilis in the expectant mother and in persons contemplating matrimony.

#### **Tuberculosis Control—With Special Reference to Hospitalization**

The hospital treatment of tuberculosis patients should not be considered merely a service to the individual, since it is a public service which protects the patient, the patient's family and the general public, and it is essential for the control of tuberculosis. While the 1930 Health Commission had as its major recommendation the construction of new State tuberculosis hospitals to cover the upstate areas needing them, the present Commission is concerned with the general problem of hospitalization of persons suffering from tuberculosis.

The bed capacity of tuberculosis hospitals located throughout New York State, exclusive of New York City, totals 5,537, of which 1,139 beds are located in the four State tuberculosis hospitals, 3,567 in county tuberculosis hospitals and 821 in municipal tuberculosis hospitals—representing in 1938 a ratio of 2.4 beds per death—which should be compared with the desirable ratio of 3 and the minimum ratio of 2 beds per annual death from tuberculosis. A study of existing beds in the 30 county and city tuberculosis hospitals reveals that this ratio varies from county to county from 5.5 to 1.1—and that only six counties have a ratio of less than 2 beds per death.

The capital investment in the 30 county and city tuberculosis hospitals and the four State tuberculosis hospitals is 21 million dollars and 5½ million dollars respectively—with annual expenditures for maintenance of 4.3 million dollars and 1.5 million dollars.

There is a wide diversity in the source of funds used in the operation of tuberculosis hospitals in Upstate New York. The original development of tuberculosis hospital facilities showed some counties and cities assumed the responsibility for the construction and maintenance of such hospitals. The expenses of hospitalization for patients, from neighboring counties not having a tuberculosis hospital and, who were unable to pay, were charged back to the county

of their residence. During the period 1932 to 1938 three new tuberculosis hospitals of 200 bed capacity each were constructed and the capacity of the Raybrook State Hospital was increased. These State hospitals are designed to serve those counties in the State which do not maintain their own tuberculosis sanatoria—and \$2.50 per day toward the cost of hospitalization of patients unable to pay was charged back to these counties.

Because of the varying degree to which county and city tuberculosis hospitals are eligible or take advantage of State aid for their operating expenses and the variable reductions in case and death rates from tuberculosis, some counties are not fully utilizing existing tuberculosis facilities, while other counties lack beds to meet present demands.

There is no question that there are a sufficient number of cases of tuberculosis in Upstate New York to occupy all the available beds—however, economic, social, industrial, financial and domestic influences deter many patients from accepting hospitalization—and some of the county and city tuberculosis hospitals render services of such poor quality that they fail to secure a full return from their investment for the tuberculosis control. A tuberculosis hospital can adequately serve the area under its jurisdiction only when it utilizes adequate modern diagnostic and therapeutic equipment and has an active case finding and case follow-up service.

Should the tuberculosis death rate continue to decline it will be necessary for public authorities to arrange for a more effective utilization of available beds for tuberculosis, so that areas of large population with higher death and case rates may have the use of a sufficient number of beds and the smaller areas may be served by larger and better equipped tuberculosis hospitals.

From the standpoint of public economy, it will be necessary to devise some method whereby the cost of hospital care for tuberculosis patients may be paid for in a manner permitting the patients to be moved from one area to the other without the restrictive and burdensome methods which now exist.

The Public Welfare Law (Section 86), the County Law (Sections 45 to 49-E) and the Public Health Law (Sections 339 and 340) each provide different methods for the admission to hospitals and the determination of eligibility for care of patients suffering from tuberculosis. Although each of these laws was originally designed for a specific purpose relating to the hospitalization of patients suffering from tuberculosis and different agencies were charged with the determination of eligibility for care, it is reported that, due to a considerable overlapping and duplication in the scope of these laws, in many instances the determination of eligibility to pay for necessary care is referred to the local commissioner of public welfare for decision. It is further reported that, patients in many counties who are not already receiving other forms of public relief, have a hard time in securing hospitalization at public expense.

This practice of placing hospitalization of tuberculosis cases on a public welfare rather than on a public health basis is reported to have a serious direct and indirect influence on the control of the



disease—since the hospitalization of patients suffering from tuberculosis is fundamentally a public service for the protection of the health of other people.

Since in county and city tuberculosis hospitals in Upstate New York the total amount of money received from patients who were able to pay for part or all of their care represents less than 3 percent of the total cost of maintaining these hospitals, yet many economic barriers seem to prevent early hospitalization and treatment of many cases of tuberculosis, it is apparent that there is an urgent need for amendments to the present laws, as well as changes in the present practices, to insure hospitalization for tuberculosis on a public health rather than on a public welfare basis.

Steps also need to be taken to correct the present maldistribution of tuberculosis hospital beds in Upstate New York, with the introduction of operating economies so that people from every section of the State can be provided with an equal opportunity for treatment as well as for protection from the spread of this disease.

Among the recommendations to achieve these objectives are:

1. State-wide operation of all tuberculosis hospitals on a regional basis so that vacant beds in one county can be used in meeting the immediate needs of neighboring counties;
2. A combination of State operation of some hospitals and State-aid for others; and,
3. State-aid for all local public tuberculosis hospitals.

In New York City the problem of the need for the hospitalization of tuberculosis patients is even more urgent since there is only one bed for each annual death from tuberculosis as compared with a ratio of 2.4 beds in Upstate New York. It has been estimated that at least 5,000 additional beds for tuberculosis patients are needed to meet present requirements in New York City.

An actual barrier to a suitable system of tuberculosis control is the division of public responsibility—with the hospital facilities consolidated under the Department of Hospitals; registering, case finding and supervision of tuberculosis patients under the Department of Health; and both the Departments of Health and Hospitals operating independent consultative therapeutic and follow-up clinics in New York City.

### **Dental Care—With Emphasis on Oral Hygiene in Childhood**

The widespread need for dental care has been revealed in many surveys. Studies in New York City have shown that more than 90 percent of the school children have dental disease—and most adults have some dental disorder.

Dentistry is expensive when compared with other health services—the common estimate being \$10 per year per child for the first two years and \$5 annually thereafter.

If oral hygiene is neglected in childhood much higher costs are involved—\$84 being the estimate of the total cost, at clinic rates, of dental rehabilitation for the average adult in the urban areas.

By maintaining good oral hygiene in childhood the need for extensive dental restorative work in adult life should be materially reduced. Oral hygiene can be maintained by promotion of good

nutrition and general bodily health, not only as a part of the school hygiene program supervised by the Department of Education in New York State but also by special oral hygiene programs designed to serve individuals not reached by this program—such as infants, pre-school children and pregnant women—among whom preventive efforts yield the highest returns.

The Division of Maternity, Infancy and Child Hygiene of the State Department of Health has recently developed an oral hygiene program under the direction of a full-time dentist, with full sponsorship and participation by the State and local dental societies. During 1939 clinics organized in 101 communities in 14 upstate counties used local part-time dentists and dental hygienists to care for 198 infants, 118 pregnant women and 3,217 pre-school children.

In New York City the Dental Division of the City Department of Health during 1938 operated 135 clinics, the majority in public schools, serving 87,141 children during 354,791 visits. This New York City program should be compared with the 1934 figures when 83 clinics served 51,580 children in the course of 165,622 visits. The dental services provided through this program are educational, prophylactic and operative.

### Drug Addiction Control

Narcotic addiction is now recognized as a disease entity, with definite symptoms—with special interest to the community because of the psychological and social adjustments involved. Although no reporting of narcotic addiction is required, it is estimated that there are at least 4,000 addicts in New York State.

The narcotic addict is most dangerous to society when he cannot secure the supply of the drug he needs to prevent violent withdrawal symptoms—with the result that he may resort to crime to obtain it. Since factors which lead to law-breaking may also predispose to drug addiction—there is no doubt that in many instances proper medical treatment in a hospital may achieve more in terms of the rehabilitation of the individual than incarceration in a penal institution.

At the present time the State mental hospitals provide the only State facilities for the treatment of drug addiction; both public and private general hospitals are reluctant to admit drug addicts since they are difficult and undesirable patients; and care in private institutions, designed for the purpose, is prohibitively expensive.

A recent study indicates that it would be “financially impossible and of problematic worth for the community to provide facilities for the long-term care of all addicts.”<sup>1</sup> This same report suggests that experimental research in a privately endowed institution designed to study causes and treatment of alcoholism and drug addiction “may eventually lead the way to a better understanding of how to deal with this problem on a more comprehensive scale through public agencies.”

<sup>1</sup> Report of Sub-Committee of Committee on Public Health Relations, New York Academy of Medicine.

This Health Commission recognizes that the control of narcotic addiction is one of the many problems involved in the development of a comprehensive State health program.

### **Physical and Social Rehabilitation for Handicapped Children**

The New York State Department of Health, following the poliomyelitis epidemic in 1916, began a program of rehabilitation of handicapped children through the development of a program. The State Legislature in 1926 amended the Children's Court Act and the State Education Law to implement a specific program for this rehabilitation—and on recommendation of the 1930 State Health Commission, the Division of Orthopedics was established in the State Department of Health to supervise and provide professional services in this field.

The program of rehabilitation of crippled children is a joint responsibility of the local communities, the Children's Courts and the State Departments of Health and Education. Public funds are expended for the care of a crippled child, usually on the basis of an order by a Children's Court judge and, since medical services for these children is so expensive and prolonged as to be prohibitive in cost for the average family, if the State Departments of Health and Education approve the services requested, State aid up to one-half of the approved cost is granted to the local community from a fund in the State Department of Education.

The Division of Orthopedics in the State Department of Health is supervised by an orthopedic physician and central office staff with a part-time district State orthopedic surgeon in charge of each of the five districts in the State—supplemented by 32 State orthopedic nurses engaged in field work. The activities of the Division of Orthopedics and its field personnel include diagnosis, treatment, supervision of care and follow-up of all orthopedic cases reported to it. In addition orthopedic services are given to the State tuberculosis hospitals and several institutions under the State Department of Correction.

During 1939, 360 clinic sessions were held with an attendance of 12,245 patients, of whom 2,917 were new patients; the orthopedic nurses made 32,513 visits to or in behalf of 8,381 patients, or about four visits per patient.

The total expenditures approved for State aid, upon 2,922 orders by Children's Court judges, was \$916,688.91, an increase of about \$140,000 over the previous year.

### **Extension of Approved Laboratory Facilities and Services**

The service rendered in behalf of patients to physicians by laboratories in the discovery, identification, prevention and treatment of disease is indispensable to the application of biology to the modern practice of medicine and the promotion of the health of the public. In New York State 424 hospitals maintain clinical laboratories and 96 hospitals send out all of their laboratory diagnostic work. There are now approximately 130 local diagnostic laboratories in Upstate New York approved by the State Department



of Health and located in 45 of the 57 upstate counties. With important exceptions, all sections of the State are within reach of these laboratories most of which are located in hospitals.

An approved laboratory must be directed by a physician, thoroughly trained in pathology as well as in other diagnostic laboratory procedures and qualified to act as a consultant; and, equipped to perform all of the principal tests considered essential to the efficient practice of medicine.

The progress and development of local laboratory service in the State are shown by the number of examinations made in approved laboratories, namely 3,956,092 in 1938 contrasted with 102,000 in 1915—and during the same period examinations conducted by the State Health Department Laboratory increased from 48,000 to 651,903. Antitoxins, sera and vaccines are prepared and distributed to physicians free of charge by the Division of Laboratories and Research in the State Department of Health through 200 district laboratory supply stations distributed throughout Upstate New York. Notable among these are anti-pneumococcus sera for many types, as well as diagnostic sera and reagents standardized by the State and distributed to approved laboratories to promote accuracy and uniformity of diagnostic procedures.

To permit necessary laboratory work being performed at a moderate charge or free and to establish new laboratories for this purpose, particularly in rural areas, State aid is granted for the maintenance of laboratories in six cities and 19 counties and for reimbursement for services rendered under contracts with six additional counties.

In the judgment of competent experts, the recommendation made by the Commission in its Preliminary Report<sup>2</sup> for the improvement and extension of laboratory services can be realized if the following steps are taken:

1. Further development of diagnostic service by continuing grants of State aid to county and city laboratories and by encouraging expansion of such approved systems or their establishment where such services cannot be provided by arrangements with existing laboratories, so that facilities including the advice and counsel of competent experts in pathology and bacteriology through personal consultation locally, are readily available to every physician in the State.

2. Further provision as indicated of diagnostic, prophylactic and therapeutic preparations by the State Department of Health, so that the general practitioner may have these essential aids within reach for his patients in all income brackets.

3. Continuation and extension of research and related field studies by State and local laboratories with the aim of improving and developing technical methods and thus of providing more efficient or new aids to the practicing physician particularly in such baffling but urgent problems as the virus diseases and those of indeterminate nature.

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<sup>2</sup> Preliminary Recommendation 6, Legislative Document (1939) No. 97, p. 4.

# MEDICAL CARE

## In New York State

### 1939

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## Chapter I

### MEDICAL CARE IN WELFARE DISTRICTS, NOVEMBER, 1939

New York State (Exclusive of New York City)

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#### Scope and Method of Study

Any long range state health program which takes into account all of the medical and health needs of each man, woman and child living in the state should have as its foundation the provisions of medical care of good quality both for persons receiving other forms of public assistance and for persons otherwise self-supporting, but unable to pay for necessary medical care. Persons in the lower income groups are a primary concern.

The Public Welfare Law\* states that "The public welfare district shall be responsible for providing necessary medical care for all persons under its care, and for such persons otherwise able to maintain themselves, who are unable to secure necessary medical care. Such care may be given in dispensaries, hospitals, the person's home or other suitable place." The programs administered by the welfare departments in discharging this responsibility are described in Chapter II of this report.

In order to evaluate the problems and methods in administering medical and hospital care to persons without relief status, a study of the upstate welfare districts was undertaken for the month of November 1939, a month which may well be regarded as typical for a study of this nature. In October 1939, letters were sent to the county and city commissioners of public welfare of the 107 upstate local welfare agencies, requesting on Forms MC-1, MC-2 and MC-2a (see Appendices A, B, and C, pages 435 to 448), the following information:

1. A general report (Form MC-1) covering medical care of all types authorized during the month of November 1939 showing:

- a. The number of authorizations to persons with relief status and the number to persons with non-relief status.

It should be noted that the term "relief status" as used in this study refers to individuals who were recipients of public relief, i.e., Home Relief (including Veteran Relief), Old Age Assistance, Aid to Dependent Children, Assistance to the Blind, Institutional or Foster Home Care, or any form of public relief, with the exception of Work Relief (WPA).

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\* Section 83, Article X, see page 19 for 1940 amendments.



- b. The types of relief received by the persons with relief status.
- c. The age distribution of the persons authorized to receive medical or hospital care.

2. A report (Form MC-2a) for each application for medical care from a person not receiving any form of public relief, pending on November 1, and received during the month of November. This form was designed to show the relief history and economic status of the applicant, the type of medical care involved and the decision of the public welfare official on the case.

3. A summary report (Form MC-2) of the volume of applications for medical care by persons with non-relief status. This served as a control report to determine whether the correct number of reports for applications pending on November 1 and received during November was submitted by each district.

In those counties where medical care is administered on a town basis, the county commissioner was requested to secure the desired information regarding the town cases. Inasmuch as data concerning the availability of medical care in rural areas are of great importance, the county commissioners were urged to make a special effort to secure this information on behalf of the Commission. Each town was to submit its reports (Forms MC-1, MC-2 and MC-2a) at the expiration of the period of study to the county commissioner. The commissioner in turn utilized these reports in compiling the report for the entire county.

### Size of Sample

Reports were received from 78 welfare districts in time to be included in this study. Of this number, 75 submitted the general report on Form MC-1. These 75 districts represented 75 percent of the total number of cases receiving public assistance (Home Relief, Old Age Assistance, Aid to Dependent Children and Assistance to the Blind) in upstate districts during the month of November.

#### UPSTATE WELFARE DISTRICTS REPORTING ON APPLICANTS FOR MEDICAL OR HOSPITAL CARE, WITH RELIEF STATUS, AND CASELOAD COVERED, NOVEMBER, 1939

ITEM	Total	REPORTING	
		Number	Percent
Districts .....	107	75	70.1
Recipients of public assistance:			
Cases .....	186,711	140,006	75.0
Individuals .....	484,288	370,747	76.6

A total of 40,672 persons who were receiving some form of public relief was reported by these districts as being authorized to receive medical or hospital care. By relating this number to the total number of persons receiving public assistance during the same month, we find that 11 percent of the relief population in the districts included in the study were provided with medical care by the welfare agencies. The number of persons receiving medical care includes those who were receiving institutional or foster home care while the total number of persons receiving relief includes public assistance recipients only. However, the number of persons reported as receiving institutional or foster home care was negligible.

Seventy-one of the 107 upstate districts, or 66.4 percent, submitted data on applications for medical or hospital care made by persons with non-relief status, during November 1939. These districts represent 74.2 percent of the total population upstate.

UPSTATE WELFARE DISTRICTS REPORTING ON APPLICANTS FOR  
MEDICAL OR HOSPITAL CARE, WITH NON-RELIEF STATUS, AND  
POPULATION COVERED, NOVEMBER, 1939

ITEM	Total	REPORTING	
		Number	Percent
Districts.....	107	71	66.4
Population (1930).....	5,657,620	4,199,548	74.2

Reports were received for 2,893 applications which were either pending at the beginning of the month or were received during the month. In a few instances, the number of reports submitted did not cover all applications. However, on the basis of the sample covered, it is fair to assume that the picture as presented in this study reflects, in the main, for the upstate area, the conditions of persons without relief status, but in need of medical care.

### Summary of Findings of Data

*Disposition of Applications.* Of the 2,893 applications received, a total of 1,714, or 59.2 percent, were approved for medical or hospital care during the month, while 512 applications, or 17.7 percent, were denied by the departments of public welfare. The remaining 667 represented applications on which no action had been taken as of November 30. It is interesting to note that of the 512 applications denied, 352, or 69.2 percent, of the applicants were considered, after investigation by the welfare agencies, to be able to pay for their own medical care. Of these, 309 applicants, or 60.7 percent, were considered able to pay through their own

resources while the remaining group had to resort to the assistance of legally responsible relatives outside of their own household or to some other means.

*Type of Care Requested.* An analysis of the type of care requested by persons with non-relief status shows that almost 85 percent of the applications were for hospital care or for medical and hospital care. A relatively small number, or 15 percent, were for medical care only. This bears out the fact that the illnesses requiring hospital care which involve greater costs are the ones with which families cannot cope and which force them to apply for free care. In general, the non-hospitalized illnesses involve costs that are comparatively small and which families are better able to meet. Thus, families that are ordinarily self-supporting find it necessary to apply to welfare departments for medical care much less frequently for illnesses not involving hospital care than for illnesses requiring hospitalization. See Chart 4 on page 27.

*Type of Care Authorized.* A comparison of the type of medical care authorized for persons with relief status and for persons with non-relief status reveals some striking differences. One of the outstanding disparities is evidenced in hospital care which was authorized for 9.1 percent of those with relief status as compared with 79 percent of the group with non-relief status. This included obstetrical care for 0.7 percent and 11.7 percent of the persons with relief status and with non-relief status, respectively. In contrast to this are the general practitioners whose services were authorized for 45.1 percent of those on relief as against 12.3 percent of those not on relief. See Chart 1 on page 18 for comparisons.

Another major difference occurred in drug authorization which amounted to 28.5 and 2.1 percent for the relief and non-relief groups, respectively. It is to be expected that families not on relief will not apply to welfare departments for items such as drugs but will manage to find funds for these smaller expenses.

Clinic care is another such form of care which is more frequently authorized for the relief group than for the non-relief group—15.7 percent as compared with 2.8 percent. It is interesting to note that specialists are seldom used for either group—during the month under study, 2.4 percent of the persons with relief status were authorized for such services as compared with 1.3 percent of the persons with non-relief status.

*Age.* Applications were made for medical or hospital care by or on behalf of persons of all ages with non-relief status. More than half of the applicants ranged from 20 to 55 years. There was noticeable similarity between the age distribution of this group and the relief group. However, the relative number of persons 65 years and over differed considerably. This age group accounted for 25.5 percent of the total on relief while it represented only 6.1 percent of those not receiving any form of public relief. This disparity is not surprising since the relief group is weighted by



the Old Age Assistance recipients who are frequently in need of medical care. There was also a significant difference in those 20 to 35 years of age. This group constituted 13.4 percent of the total number with relief status in contrast to 29.6 percent of those with non-relief status. See Charts 2-5, on pages 25-28, for comparisons relating to age distribution.

*Source of Application.* The largest single source of applications for free medical or hospital care, made to welfare departments for persons not on relief was the hospital. Of the 2,702 applications for which the source was reported, 1,200, or 44.4 percent, were made through this channel. It appears that a common procedure is for a person in need of medical care to go first to the hospital where he is admitted as a patient. The hospital then informs the welfare department of the patient's admission and of his inability to pay the bill and requests an investigation which will lead to acceptance of the bill by the welfare department. The next most common source of application was a member of the patient's family or household. This group was responsible for 661, or 24.5 percent, of the applications. In 17.9 percent of the applications, the patient himself applied, while in 9.7 per cent of the cases the application was made by a physician.

Of the applications received through hospitals, only 52.1 percent were approved as against 74.1 percent of those made by physicians. This may be due not only to the fact that hospital cases involve greater costs, but also that in many instances, the hospital does not investigate or cannot determine the resources of persons able to pay their own bills—and hence refer them to the welfare department. The source and disposition of applications for medical or hospital care are graphically portrayed in Chart 6, on page 29.

*Diagnostic Groups.* The diagnoses of illnesses as reported for applicants with non-relief status were classified according to 16 standard groups. Diseases of the digestive system accounted for the largest single number of applications—379, or 14.2 percent. The next most frequent diagnostic groups were puerperal state, traumatic conditions and poisonings, and diseases of the respiratory system comprising 12.6, 12.3 and 12.1 percent of the cases, respectively. See Chart 7, on page 30.

*Relief History.* "Relief," as mentioned above, relates to public relief, excluding work relief (WPA) and may refer to applicants or their families. Almost two-thirds of the applicants who were not on relief at the time of application had been on relief at some time prior to or during 1939, or during both of these periods. There was a larger proportion of cases previously on relief among the approved group (67.2 percent) than among those rejected for medical or hospital care (58.7 percent). This is to be expected since the chief reason for disapproving a case for medical care is that the family is considered financially able to pay for its care and therefore would be less likely to have been in need of relief. See Chart 8, on page 31.

*WPA History.* WPA may have been interpreted to include work programs other than WPA. In slightly over three-fourths of the cases no member of the household had ever been employed on WPA. Of those where the applicant or some other member of the family had a WPA history only about half were so employed at the time of application for medical care. A significant difference is indicated by the fact that 72.1 percent of applicants approved were never employed on WPA projects as compared with 85.1 percent of those denied. See Chart 9, on page 32.

*Income of Family.* A comparison of the monthly average cash income of families of applicants during illness and during the year prior to onset of illness indicates that the average income for the group was considerably reduced during the period of illness. This comparison was made for 1,547 applicants for whom data on cash income were reported. The average monthly cash income during illness was found to be \$55.82 as against \$62.04 during the year prior to illness.

Further evidence of the difference in the economic status of the approved and denied groups is borne out by the fact that during the period of the present illness the average monthly income of those approved was \$53.63 in contrast to \$84.32 reported for those rejected.

It should be noted that income as referred to here applies only to cash income and does not include "income in kind," such as free rent, board, fuel, light, milk and farm produce. These items, singly or in various combinations, were reported in a small number of cases either in addition to cash income or where there was no cash income.

*Assets.* Information on insurance was available for 1,865 out of 2,893 cases. More than one-third of the 1,865 cases were reported to have insurance ranging in value from less than \$25 to over \$5,000. In a small number of cases the insurance was reported as having no cash or adjustment value, while in almost 8 percent of the applications the insurance was reported as adjusted or in the process of adjustment. This involved, with few exceptions, applicants approved for medical care.

Thirteen percent of the applicants were reported to have real estate which had an assessed valuation ranging from \$25 to over \$5,000. About 5 percent had bank accounts, while approximately 6 percent had some farm and garden products on hand. A comparison of the approved and denied groups shows that a somewhat higher proportion of those whose applications were denied for medical care were reported to have insurance, real estate and bank accounts.

*Size of Family.* The size of family of all applicants with non-relief status averaged 4.1, while for the approved and denied groups the averages were 4.3 and 3.9, respectively.

*Monthly Budget to Determine Eligibility for Medical Care.* In about half of the cases for which data on budgets were available, the monthly budget used to determine eligibility for medical care was reported to be higher than the regular monthly relief budget. This proportion was also true for the applicants approved for medical care, while the denied group had a relatively larger number, or 66 percent.

That greater liberality is exercised in budgets applied for eligibility for medical care only, as compared with those used for eligibility for regular relief is indicated by the following comparative average (median) figures.

DISPOSITION	Regular monthly relief budget	Monthly budget applied for eligibility for medical care only
Total.....	\$57.68	\$74.01
Approved.....	57.72	73.67
Denied.....	60.00	77.50
Pending at end of month.....	54.17	70.00

Analyses of applicants with non-relief status were also made concerning the following (See Tables 1-39, below):

1. Diagnosis of illness classified by type of care requested.
2. Type of care requested and authorized.
3. Monthly average cash income of family in relation to size of family.
4. Monthly budget of family used to determine eligibility for medical care in relation to size of family.
5. Diagnosis classified by source of diagnosis.
6. Type of care requested classified by reason for denial.
7. Ability of family to pay for medical care.
8. Person responsible for consideration of application for medical care.



TABLE 1

New York State (Exclusive of New York City)

Study of Medical Care in Welfare Districts, November, 1939

## COMPARISON OF AGE DISTRIBUTION OF PERSONS WITH RELIEF STATUS AND WITH NON-RELIEF STATUS AUTHORIZED TO RECEIVE MEDICAL OR HOSPITAL CARE

AGE	PERSONS WITH RELIEF STATUS <sup>1</sup>		PERSONS WITH NON-RELIEF STATUS <sup>2</sup>	
	Number	Percent	Number	Percent
Total.....	40,672	.....	1,714	.....
Not reported.....	2,178	.....	16	.....
Reported.....	38,494	100.0	1,698	100.0
Under 1 year.....	830	2.1	35	2.1
1 year and under 2 years.....	734	1.9	22	1.3
2 years and under 5.....	1,577	4.1	76	4.5
5 years and under 10.....	2,686	7.0	163	9.6
10 years and under 15.....	2,732	7.1	130	7.7
15 years and under 20.....	2,156	5.6	114	6.7
20 years and under 25.....	1,530	4.0	201	11.8
25 years and under 35.....	3,620	9.4	303	17.8
35 years and under 45.....	4,498	11.7	196	11.5
45 years and under 55.....	4,610	12.0	191	11.2
55 years and under 65.....	3,708	9.6	164	9.7
65 years and over.....	9,813	25.5	103	6.1

<sup>1</sup> Based on reports of 75 districts.<sup>2</sup> Based on reports of 71 districts.

TABLE 2

## New York State (Exclusive of New York City)

Study of Medical Care in Welfare Districts, November, 1939

## COMPARISON OF TYPE OF CARE AUTHORIZED FOR PERSONS WITH RELIEF STATUS AND WITH NON-RELIEF STATUS

TYPE OF CARE	PERSONS WITH RELIEF STATUS <sup>1</sup>		PERSONS WITH NON-RELIEF STATUS <sup>2</sup>	
	Number	Percent	Number	Percent
Total .....	40,672	.....	1,714	.....
Not reported .....	91	.....	30	.....
Reported .....	\$ 40,581	\$ 100.0	\$ 1,684	\$ 100.0
Medical care .....	\$ 37,215	\$ 91.7	\$ 630	\$ 37.4
Physician .....	\$ 20,182	\$ 49.7	\$ 542	\$ 32.2
General practitioner .....	\$ 18,295	\$ 45.1	\$ 207	\$ 12.3
Office .....	7,716	19.0	104	6.2
Home .....	10,701	26.4	112	6.7
Specialist .....	982	2.4	22	1.3
Office .....	948	2.3	21	1.2
Home .....	34	0.1	1	0.1
Obstetrical care .....	465	1.1	227	13.5
Home .....	164	0.4	30	1.8
Hospital .....	301	0.7	197	11.7
Other special services by physician .....	596	1.5	113	6.7
Dental care .....	\$ 2,247	\$ 5.5	\$ 30	\$ 1.8
Extractions .....	1,272	3.1	21	1.2
Other .....	1,062	2.6	13	0.8
Nursing care .....	728	1.8	12	0.7
Registered nurse .....	467	1.2	10	0.6
Nurse housekeeper .....	261	0.6	2	0.1
Drugs .....	11,578	28.5	35	2.1
Appliances .....	2,723	6.7	15	0.9
Clinic care .....	6,353	15.7	47	2.8
Other .....	467	1.2	2	0.1
Hospital care (other than obstetrical care) .....	3,399	8.4	1,133	67.3

<sup>1</sup> Based on reports of 75 districts.<sup>2</sup> Based on reports of 71 districts.<sup>3</sup> This total does not equal the sum of the individual items since some persons were authorized to receive more than one type of care.

TABLE 3

New York State (Exclusive of New York City)

Study of Medical Care in Welfare Districts, November, 1939

DISPOSITION OF APPLICATIONS FOR MEDICAL OR HOSPITAL  
CARE OF PERSONS WITH NON-RELIEF STATUS

DISPOSITION OF APPLICATIONS	Number	Percent
Total applications.....	2,893	100.0
Disposed of during month.....	2,226	76.9
Approved.....	1,714	59.2
Denied.....	512	17.7
Family considered able to pay for own medical care . . .	352	12.2
Care available at a public or private medical agency . .	28	1.0
Private physician will treat . . . . .	1	1
Withdrawn.....	80	2.8
Other.....	48	1.6
Not reported.....	3	0.1
Pending at end of month.....	667	23.1

<sup>1</sup> Less than one-tenth of one percent.

TABLE 4

New York State (Exclusive of New York City)

Study of Medical Care in Welfare Districts, November, 1939

DENIED APPLICATIONS FOR MEDICAL OR HOSPITAL CARE OF PERSONS  
WITH NON-RELIEF STATUS, CLASSIFIED BY REASON FOR DENIAL

REASON FOR DENIAL	Number	Percent
Total applications.....	512	.....
Not reported.....	3	.....
Reported.....	509	100.0
Family considered able to pay for own medical care.....	352	69.2
Through own resources.....	309	60.7
Through assistance of legally responsible relatives outside of household.....	7	1.4
Through other means.....	33	6.5
Not reported.....	3	0.6
Care available at a public or private medical agency.....	28	5.5
Private physician will treat.....	1	0.2
Withdrawn.....	80	15.7
Other <sup>1</sup> .....	48	9.4

<sup>1</sup> Includes such reasons as unable to locate, referred to place of settlement, refused to cooperate etc.



TABLE 5  
New York State (Exclusive of New York City)  
Study of Medical Care in Welfare Districts, November, 1939  
APPLICATIONS FOR MEDICAL OR HOSPITAL CARE OF PERSONS WITH NON-RELIEF STATUS, CLASSIFIED BY  
DISPOSITION AND TYPE OF CARE REQUESTED

TYPE OF CARE REQUESTED	TOTAL APPLICATIONS		APPROVED		DENIED										PENDING AT END OF MONTH					
	Num- ber	Per- cent	Num- ber	Per- cent	TOTAL	FAMILY CONSIDERED ABLE TO PAY FOR OWN MEDICAL CARE		CARE AVAIL- ABLE AT A PUBLIC OR PRIVATE MEDICAL AGENCY		PRIVATE PHYSICIAN WILL TREAT		WITHDRAWN		OTHER <sup>1</sup>		NOT REPORTED				
						Num- ber	Per- cent	Num- ber	Per- cent	Num- ber	Per- cent	Num- ber	Per- cent	Num- ber	Per- cent	Num- ber	Per- cent	Num- ber	Per- cent	
Total.....	2,893	....	1,714	....	512	....	352	....	28	....	1	....	80	....	48	....	3	....	667	....
Not reported....	245	....	22	....	24	....	15	....	3	....	1	....	....	....	3	....	2	....	199	....
Reported.....	2,648	100.0	1,692	100.0	488	100.0	337	100.0	25	100.0	....	....	80	100.0	45	100.0	1	2	468	100.0
Medical care....	405	15.3	368	21.7	23	4.7	14	4.1	2	8.0	....	....	4	5.0	3	6.7	....	....	14	3.0
Hospital care..	2,116	79.9	1,223	72.3	457	93.7	316	93.8	22	88.0	....	....	76	95.0	42	93.3	1	2	436	93.2
Medical and hospital care	127	4.8	101	6.0	8	1.6	7	2.1	1	4.0	....	....	....	....	....	....	....	....	18	3.8

<sup>1</sup> Includes such reasons as unable to locate, referred to place of settlement, refused to cooperate, etc.

<sup>2</sup> Base too small for computing percentages.

TABLE 6

New York State (Exclusive of New York City)  
Study of Medical Care in Welfare Districts, November, 1939  
APPLICANTS FOR MEDICAL OR HOSPITAL CARE WITH NON-RELIEF  
STATUS, CLASSIFIED BY AGE AND DISPOSITION

AGE	TOTAL		APPROVED		DENIED		PENDING AT END OF MONTH	
	Num- ber	Per- cent	Num- ber	Per- cent	Num- ber	Per- cent	Num- ber	Per- cent
Total.....	2,893	.....	1,714	.....	512	.....	667	.....
Not reported.....	100	.....	16	.....	4	.....	80	.....
Reported.....	2,793	100.0	1,698	100.0	508	100.0	587	100.0
Under 1 year.....	58	2.1	35	2.1	7	1.4	16	2.7
1 year and under 2 years.....	27	1.0	22	1.3	4	0.8	1	0.2
2 years and under 5.....	112	4.0	76	4.5	16	3.1	20	3.4
5 years and under 10.....	223	8.0	163	9.6	36	7.1	24	4.1
10 years and under 15.....	187	6.7	130	7.7	27	5.3	30	5.1
15 years and under 20.....	201	7.2	114	6.7	46	9.1	41	7.0
20 years and under 25.....	310	11.1	201	11.8	54	10.6	55	9.4
25 years and under 35.....	488	17.5	303	17.8	81	15.9	104	17.7
35 years and under 45.....	345	12.3	196	11.5	74	14.6	75	12.8
45 years and under 55.....	337	12.0	191	11.2	64	12.6	82	14.0
55 years and under 65.....	316	11.3	164	9.7	62	12.2	90	15.3
65 years and over.....	189	6.8	103	6.1	37	7.3	49	8.3

TABLE 6(A)

PERCENT AGE DISTRIBUTION OF THE POPULATION IN CONTINENTAL  
UNITED STATES, NEW YORK STATE, AND NEW YORK STATE (EX-  
CLUSIVE OF NEW YORK CITY)<sup>1</sup>

AGE	Continental United States	New York State	New York State (exclusive of New York City)
Total.....	100.0	100.0	100.0
Under 1 year.....	1.8	1.5	1.5
1 year and under 2 years.....	1.8	1.5	1.5
2 years and under 5.....	5.7	4.9	5.0
5 years and under 10.....	10.3	8.6	9.0
10 years and under 15.....	9.8	8.6	8.9
15 years and under 20.....	9.4	8.5	8.3
20 years and under 25.....	8.9	9.0	8.0
25 years and under 35.....	15.4	17.5	15.2
35 years and under 45.....	14.0	15.9	15.2
45 years and under 55.....	10.6	11.4	11.9
55 years and under 65.....	6.9	7.2	8.4
65 years and over.....	5.4	5.3	7.1

<sup>1</sup> Fifteenth Census of the United States: 1930.

TABLE 6(B)

New York State (Exclusive of New York City)

Study of Medical Care in Welfare Districts

PERCENT AGE DISTRIBUTION OF TOTAL POPULATION (1930)<sup>1</sup> AND  
TOTAL APPLICANTS FOR MEDICAL OR HOSPITAL CARE WITH NON-  
RELIEF STATUS, NOVEMBER, 1939

AGE	Total popu- lation	Total applicants with non-relief status
Total.....	100.0	100.0
Under 1 year.....	1.5	2.1
1 year and under 2 years.....	1.5	1.0
2 years and under 5.....	5.0	4.0
5 years and under 10.....	9.0	8.0
10 years and under 15.....	8.9	6.7
15 years and under 20.....	8.3	7.2
20 years and under 25.....	8.0	11.1
25 years and under 35.....	15.2	17.5
35 years and under 45.....	15.2	12.3
45 years and under 55.....	11.9	12.0
55 years and under 65.....	8.4	11.3
65 years and over.....	7.1	6.8

<sup>1</sup> Fifteenth Census of the United States: 1930.



TABLE 7  
New York State (Exclusive of New York City)  
Study of Medical Care in Welfare Districts, November, 1939  
APPLICANTS FOR MEDICAL OR HOSPITAL CARE WITH NON-RELIEF STATUS, CLASSIFIED BY AGE AND TYPE  
OF CARE REQUESTED

AGE	Total	Not reported	TYPE OF CARE REQUESTED						
			Total	MEDICAL CARE		HOSPITAL CARE		MEDICAL AND HOSPITAL CARE	
				Number	Percent	Number	Percent	Number	Percent
Total.....	2,893	245	2,648	405	.....	2,116	.....	127	.....
Not reported.....	100	64	36	7	.....	29	.....	.....	.....
Reported.....	2,793	181	2,612	398	100.0	2,087	100.0	127	100.0
Under 1 year.....	58	8	50	6	1.5	43	2.1	1	0.8
1 year and under 2 years.....	27	1	26	4	1.0	21	1.0	1	0.8
2 years and under 5.....	112	11	101	24	6.0	73	3.5	4	3.1
5 years and under 10.....	223	7	216	54	13.6	146	7.0	16	12.6
10 years and under 15.....	187	8	179	54	13.6	114	5.5	11	8.7
15 years and under 20.....	201	12	189	19	4.8	161	7.7	9	7.1
20 years and under 25.....	310	15	295	19	4.8	262	12.5	14	11.0
25 years and under 35.....	488	27	461	64	16.1	373	17.9	24	18.9
35 years and under 45.....	345	24	321	51	12.8	260	12.4	10	7.9
45 years and under 55.....	337	29	308	34	8.5	261	12.5	13	10.2
55 years and under 65.....	316	24	292	52	13.0	229	11.0	11	8.7
65 years and over.....	189	15	174	17	4.3	144	6.9	13	10.2

TABLE 8

New York State (Exclusive of New York City)

Study of Medical Care in Welfare Districts, November, 1939

APPLICATIONS FOR MEDICAL OR HOSPITAL CARE OF PERSONS WITH NON-RELIEF STATUS, CLASSIFIED BY SOURCE AND DISPOSITION OF APPLICATION

SOURCE	Total applications	Approved	DENIED						Pending at end of month
			Total	Family considered able to pay for own medical care	Care available at a public or private medical agency	Private physician will treat	Withdrawn	Other <sup>1</sup>	
Total.....	2,893	1,714	512	352	28	1	80	48	667
Not reported.....	191	50	17	12	.....	.....	3	2	124
Reported.....	2,702	1,664	495	340	28	1	77	46	543
Hospital.....	1,200	625	273	208	17	.....	25	21	302
Physician.....	263	195	31	25	2	.....	.....	4	37
Patient.....	484	318	78	37	4	.....	28	8	88
Member of household.....	661	455	99	64	3	1	23	8	107
Other.....	<sup>2</sup> 94	71	14	6	2	.....	1	5	9

<sup>1</sup> Includes such reasons as unable to locate, referred to place of settlement, refused to cooperate, etc.<sup>2</sup> Includes: 29 applications made by dispensaries of which 22 were approved and 7 denied, and 32 applications made by nurses of which 29 were approved, 1 denied and 2 pending.

TABLE 9

New York State (Exclusive of New York City)

Study of Medical Care in Welfare Districts, November, 1939

PERCENTAGE DISTRIBUTION OF APPLICATIONS FOR MEDICAL OR HOSPITAL CARE OF PERSONS WITH NON-RELIEF STATUS, AS TO SOURCE OF APPLICATION

SOURCE	TOTAL		APPROVED		DENIED		PENDING AT END OF MONTH	
	Num- ber	Per- cent	Num- ber	Per- cent	Num- ber	Per- cent	Num- ber	Per- cent
Total.....	2,893	.....	1,714	.....	512	.....	667	.....
Not reported.....	191	.....	50	.....	17	.....	124	.....
Reported.....	2,702	100.0	1,664	100.0	495	100.0	543	100.0
Hospital.....	1,200	44.4	625	37.6	273	55.1	302	55.6
Physician.....	263	9.7	195	11.7	31	6.3	37	6.8
Patient.....	484	17.9	318	19.1	78	15.8	88	16.2
Member of household.....	661	24.5	455	27.3	99	20.0	107	19.7
Other.....	94	3.5	71	4.3	14	2.8	9	1.7

TABLE 10

New York State (Exclusive of New York City)

Study of Medical Care in Welfare Districts, November, 1939

APPLICANTS FOR MEDICAL OR HOSPITAL CARE WITH NON-RELIEF STATUS, CLASSIFIED BY RELIEF HISTORY OF APPLICANT OR FAMILY

RELIEF HISTORY	TOTAL		APPROVED		DENIED		PENDING AT END OF MONTH	
	Num- ber	Per- cent	Num- ber	Per- cent	Num- ber	Per- cent	Num- ber	Per- cent
Total.....	2,893	.....	1,714	.....	512	.....	667	.....
Not reported.....	249	.....	37	.....	23	.....	189	.....
Reported.....	2,644	100.0	1,677	100.0	489	100.0	478	100.0
Not on relief previously...	969	36.6	550	32.8	202	41.3	217	45.4
Previously on relief.....	1,675	63.4	1,127	67.2	287	58.7	261	54.6
Prior to 1939.....	721	27.3	434	25.9	156	31.9	131	27.4
Prior to and during 1939	536	20.3	394	23.5	81	16.6	61	12.8
During 1939 only.....	418	15.8	299	17.8	50	10.2	69	14.4



TABLE 11

New York State (Exclusive of New York City)

Study of Medical Care in Welfare Districts, November, 1939

APPLICANTS FOR MEDICAL OR HOSPITAL CARE WITH NON-RELIEF STATUS, CLASSIFIED BY WPA HISTORY OF APPLICANT OR FAMILY

WPA HISTORY	TOTAL		APPROVED		DENIED		PENDING AT END OF MONTH	
	Num- ber	Per- cent	Num- ber	Per- cent	Num- ber	Per- cent	Num- ber	Per- cent
Total.....	2,893	.....	1,714	.....	512	.....	667	.....
Not reported.....	352	.....	105	.....	30	.....	217	.....
Reported.....	2,541	100.0	1,609	100.0	482	100.0	450	100.0
Never on WPA.....	1,930	76.0	1,160	72.1	410	85.1	360	80.0
On WPA.....	611	24.0	449	27.9	72	14.9	90	20.0
At time of application..	313	12.3	245	15.2	29	6.0	39	8.7
Not at time of appli- cation.....	298	11.7	204	12.7	43	8.9	51	11.3
Prior to 1939.....	160	6.3	106	6.6	27	5.6	27	6.0
Earlier in 1939.....	90	3.5	67	4.2	7	1.4	16	3.5
Prior to and earlier in 1939.....	48	1.9	31	1.9	9	1.9	8	1.8

TABLE 12  
New York State (Exclusive of New York City)  
Study of Medical Care in Welfare Districts, November, 1939  
APPLICATIONS FOR MEDICAL OR HOSPITAL CARE OF PERSONS WITH NON-RELIEF STATUS, CLASSIFIED BY  
MONTHLY AVERAGE CASH INCOME<sup>1</sup> OF FAMILY DURING ILLNESS AND SIZE OF FAMILY

MONTHLY AVERAGE INCOME	Total appli- cations	Not re- ported	SIZE OF FAMILY												
			Total	1 person	2 persons	3 persons	4 persons	5 persons	6 persons	7 persons	8 persons	9 persons	10 persons	11 persons	12 or more persons
Total.....	2,860	309	2,551	443	362	429	406	314	227	143	93	74	27	22	11
Not reported.....	897	227	670	143	112	113	95	81	53	24	26	16	4	.....	3
Reported.....	1,963	82	1,881	300	250	316	311	233	174	119	67	58	23	22	8
None.....	483	36	447	231	462	453	437	28	14	8	4	8	1	1	.....
Under \$5.....	1	.....	1	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....
\$5 and under 10.....	10	.....	10	2	6	1	.....	1	.....	.....	.....	.....	.....	.....	.....
10 and under 15.....	17	.....	17	2	4	5	3	1	.....	.....	.....	.....	.....	.....	.....
15 and under 20.....	22	.....	22	5	10	3	.....	2	2	1	1	.....	.....	.....	.....
20 and under 25.....	40	.....	40	8	8	10	5	.....	2	2	2	2	1	.....	.....
25 and under 30.....	49	.....	49	10	13	4	8	3	3	2	.....	.....	.....	.....	.....
30 and under 35.....	48	.....	48	4	18	9	10	9	3	1	.....	.....	.....	.....	.....
35 and under 40.....	48	.....	48	2	12	11	6	1	3	3	5	1	2	4	.....
40 and under 45.....	91	6	85	3	19	10	23	12	10	3	3	1	2	.....	.....
45 and under 50.....	65	3	62	2	7	12	15	12	7	2	2	1	2	.....	.....
50 and under 55.....	130	8	122	6	26	35	23	11	13	2	1	1	2	.....	.....
55 and under 60.....	85	2	83	3	17	21	20	12	3	3	1	3	.....	.....	.....
60 and under 65.....	129	3	126	7	12	29	29	14	13	11	6	2	2	3	.....
65 and under 70.....	79	.....	79	.....	9	15	21	15	11	5	.....	1	1	1	.....
70 and under 75.....	59	2	57	1	6	11	10	10	5	6	4	1	1	1	.....
75 and under 80.....	53	3	50	.....	4	10	11	6	5	7	1	3	1	1	.....
80 and under 85.....	87	5	82	.....	5	13	19	14	20	8	1	1	2	2	.....
85 and under 90.....	51	.....	51	3	6	8	10	9	5	5	5	5	2	2	.....
90 and under 95.....	51	1	50	3	1	7	8	10	5	5	5	5	1	4	.....
95 and under 100.....	36	1	35	1	2	5	2	7	7	3	3	3	4	2	.....
100 and under 105.....	75	1	74	1	3	12	13	15	10	6	4	6	2	2	1
105 and under 110.....	24	.....	24	.....	2	4	2	4	4	7	1	.....	.....	.....	.....
110 and under 115.....	20	.....	20	.....	1	1	3	1	1	3	.....	2	.....	2	.....

[illegible]

<sup>1</sup> Estimated.

<sup>2</sup> Excludes applications of 33 individuals: 6 in institutions, 18 in boarding houses and 9 in homes where they were employed as domestics.

3 Includes applications of 2 individuals whose relatives provided for living expenses.

<sup>4</sup> Includes application of 1 individual whose relatives provided for living expenses.



TABLE 13

New York State (Exclusive of New York City)

Study of Medical Care in Welfare Districts, November, 1939

APPROVED APPLICATIONS FOR MEDICAL OR HOSPITAL CARE OF PERSONS WITH NON-RELIEF STATUS,  
CLASSIFIED BY MONTHLY AVERAGE CASH INCOME<sup>1</sup> OF FAMILY DURING ILLNESS AND SIZE OF FAMILY

MONTHLY AVERAGE INCOME	Total appli- cations	Not re- ported	SIZE OF FAMILY												
			Total	1 person	2 persons	3 persons	4 persons	5 persons	6 persons	7 persons	8 persons	9 persons	10 persons	11 persons	12 or more persons
Total.....	21,690	77	1,613	246	218	268	280	211	140	102	58	50	17	17	6
Not reported.....	304	30	274	49	51	47	47	32	18	12	11	6			1
Reported.....	1,386	47	1,339	197	167	221	233	179	122	90	47	44	17	17	5
None.....	329	19	310	151	44	36	27	26	11	6	1	6	1	1	
Under \$5.....	1		1	1											
5 and under \$10.....	9		9	2	5	1	3	1							
10 and under 15.....	14		14	2	2	4		1		1		1			
15 and under 20.....	16		16	5	6	2		2		2	1	2		1	
20 and under 25.....	32		32	6	6	8	5	3	3	2		2			
25 and under 30.....	40		40	7	11	3	7	3	5	2		2			
30 and under 35.....	41	4	37	4	7	6	8	8							
35 and under 40.....	32		32	2	7	5	6				5			4	
40 and under 45.....	68	6	62	1	13		18	10	6	3	1	1			
45 and under 50.....	53	3	49	2	6	12	13	9	4	2					
50 and under 55.....	100	5	95	3	17	31	18	9	10	1	1	1	2	2	
55 and under 60.....	74	1	73	3	16	20	18	7	3	3	1	2			
60 and under 65.....	93	2	91	3	9	18	23	12	11	8	5	1		1	
65 and under 70.....	62		62		4	12	17	13	10	5				1	
70 and under 75.....	43		43	1	3	7	8	10	2	6	3	1	1	1	
75 and under 80.....	38	2	36		2	7	7	4	4	6	1	2	1	1	
80 and under 85.....	66	2	64	1	3	6	18	9	18	7	1	2	2		
85 and under 90.....	32		32		2	5	5	6	4	3	2	3	1		
90 and under 95.....	37		36	1		5	5	7	5	3	5	4	1		
95 and under 100.....	23		23	1		3	1	2	6	3	3	1	3		
100 and under 105.....	49	1	48		1	7	6	13	5	3	2	5	2	1	
105 and under 110.....	10		10				1	2	4	3					
110 and under 115.....	14		14			3	2	1	1	3		2		2	















TABLE 16

New York State (Exclusive of New York City)

Study of Medical Care in Welfare Districts, November, 1939

APPLICANTS FOR MEDICAL OR HOSPITAL CARE WITH NON-RELIEF  
STATUS, CLASSIFIED BY DISPOSITION AND SIZE OF FAMILY

DISPOSITION	Number of applicants <sup>1</sup>	Average <sup>2</sup> number of persons per family
Total.....	2,551	4.1
Approved.....	1,613	4.3
Denied.....	458	3.9
Pending at end of month.....	480	3.7

<sup>1</sup> Excludes applicants for whom data were not available.<sup>2</sup> Expressed as a median.

TABLE 17

New York State (Exclusive of New York City)

Study of Medical Care in Welfare Districts, November, 1939

APPLICATIONS FOR MEDICAL OR HOSPITAL CARE OF PERSONS WITH NON-RELIEF STATUS, CLASSIFIED BY MONTHLY AVERAGE CASH INCOME<sup>1</sup> OF FAMILY DURING ILLNESS AND DURING YEAR PRIOR TO ONSET OF ILLNESS

MONTHLY AVERAGE INCOME DURING YEAR PRIOR TO ONSET OF ILLNESS	Total	None	Under \$5	MONTHLY AVERAGE INCOME DURING ILLNESS												\$60 and under \$65	\$65 and under \$70
				\$5 and under \$10	\$10 and under \$15	\$15 and under \$20	\$20 and under \$25	\$25 and under \$30	\$30 and under \$35	\$35 and under \$40	\$40 and under \$45	\$45 and under \$50	\$50 and under \$55	\$55 and under \$60	\$60 and under \$65		
Total.....	2,893	908	1,985	497	1	11	18	22	40	49	49	66	131	85	129	79	
Not reported.....	1,268	830	438	135	1	4	3	3	13	10	10	24	30	15	29	17	
Reported.....	1,625	78	1,547	362		7	15	19	27	39	39	42	101	70	100	62	
None.....	158	3	155	107			1		1	1	1		5	12	2	1	
Under \$5.....	1		1														
\$5 and under \$10.....	8	1	7	3		2	1	1									
10 and under 15.....	23	2	21	11			8	1				1					
15 and under 20.....	30	2	28	12		2	2	9				1			1		
20 and under 25.....	45	9	36	15			1		16		1	1			2		
25 and under 30.....	65	3	62	25		1		1	1	2	2	2	2		2		
30 and under 35.....	58	2	56	23					1	2	2		2		1		
35 and under 40.....	27	1	26	7					1	15	1		3		2		
40 and under 45.....	114	8	106	32				1	6	1	1		51		1		
45 and under 50.....	56	4	52	12				2	2	5	2	24	68		3		
50 and under 55.....	123	6	117	25		1		1	1	4	2	2	3		1		
55 and under 60.....	59	1	58	10				1	1	1	2	2	10	38	1		
60 and under 65.....	121	2	119	11				1		1	1	2	7	7	66		
65 and under 70.....	55	4	51	2			1		1	1	2	2	1		1		
70 and under 75.....	45	1	44	4				1			1	1	1	4	1		
75 and under 80.....	47	3	44	1									2	2	3		
80 and under 85.....	89	4	85	10									2		5		

<sup>1</sup> Estimated.

<sup>2</sup> Includes application of 1 individual whose relatives provided for living expenses during illness.

<sup>3</sup> Includes applications of 3 individuals whose relatives provided for living expenses.

TABLE 17 — (Continued)

MONTHLY AVERAGE INCOME DURING YEAR PRIOR TO ONSET OF ILLNESS	Total ap- pli- cations	Not re- ported	MONTHLY AVERAGE INCOME DURING ILLNESS — (Continued)															
			Total	None	Under \$5	\$5 and under \$10	\$10 and under \$15	\$15 and under \$20	\$20 and under \$25	\$25 and under \$30	\$30 and under \$35	\$35 and under \$40	\$40 and under \$45	\$45 and under \$50	\$50 and under \$55	\$55 and under \$60	\$60 and under \$65	\$65 and under \$70
85 and under 90.....	48	3	45	5	....	....	....	....	....	....	....	....	....	1	1	1	2	2
90 and under 95.....	54	5	49	1	....	....	....	....	....	....	....	....	....	....	....	....	2	3
95 and under 100.....	18	1	17	1	....	....	....	....	....	....	....	....	....	....	....	....	1	1
100 and under 105.....	98	1	97	1	....	....	....	....	....	....	....	....	....	....	....	....	1	1
105 and under 110.....	29	2	26	2	....	....	....	....	....	....	....	....	....	....	....	....	1	1
110 and under 115.....	19	2	17	1	....	....	....	....	....	....	....	....	....	....	....	....	1	1
115 and under 120.....	25	....	25	2	....	....	....	....	....	....	....	....	....	....	....	....	1	1
120 and under 125.....	32	1	31	2	....	....	....	....	....	....	....	....	....	....	....	....	1	2
125 and under 130.....	21	1	20	1	....	....	....	....	....	....	....	....	....	....	....	....	1	2
130 and under 135.....	16	1	15	1	....	....	....	....	....	....	....	....	....	....	....	....	1	2
135 and under 140.....	14	....	14	....	....	....	....	....	....	....	....	....	....	....	....	....	....	....
140 and under 145.....	15	....	15	....	....	....	....	....	....	....	....	....	....	....	....	....	....	....
145 and under 150.....	10	....	10	....	....	....	....	....	....	....	....	....	....	....	....	....	....	....
150 and over.....	80	1	79	8	....	....	....	....	....	....	....	....	....	....	....	....	....	....
Irregular.....	22	3	19	12	....	....	....	....	....	....	....	....	....	....	....	....	....	....

<sup>1</sup> Includes application of 1 individual whose relatives provided for living expenses during illness.



TABLE 17 — (Concluded)

TABLE 18

New York State (Exclusive of New York City)

Study of Medical Care in Welfare Districts, November, 1939

APPROVED APPLICATIONS FOR MEDICAL OR HOSPITAL CARE OF PERSONS WITH NON-RELIEF STATUS, CLASSIFIED BY MONTHLY AVERAGE CASH INCOME<sup>1</sup> OF FAMILY DURING ILLNESS AND DURING YEAR PRIOR TO ONSET OF ILLNESS

MONTHLY AVERAGE INCOME DURING YEAR PRIOR TO ONSET OF ILLNESS	Total ap- pli- ca- tions	Not re- ported	MONTHLY AVERAGE INCOME DURING ILLNESS																\$50 and under \$55	\$55 and under \$60	\$60 and under \$65	\$65 and under \$70	
			Total	None	Under \$5	\$5 and under \$10	\$10 and under \$15	\$15 and under \$20	\$20 and under \$25	\$25 and under \$30	\$30 and under \$35	\$35 and under \$40	\$40 and under \$45	\$45 and under \$50									
Total.....	1,714	313	1,401	339	1	10	15	16	32	40	42	32	68	52	101	74	93	62					
Not reported.....	566	248	318	85	1	4	2	3	9	6	9	11	10	20	26	10	25	16					
Reported.....	1,148	65	1,083	254	...	6	13	13	23	34	33	21	58	32	75	64	68	46					
None.....	1,110	3	107	275	...	...	1	...	1	1	1	...	3	...	4	12	2	1					
Under \$5.....	1	...	1	1	...	2	...	...	...	...	...	...	...	...	...	...	...	...					
\$5 and under \$10.....	7	1	6	2	...	...	1	1	...	...	...	...	...	1	...	...	...	...					
10 and under 15.....	20	2	18	9	...	...	7	1	...	...	...	...	...	...	...	...	...	...					
15 and under 20.....	24	2	22	10	...	1	2	6	...	...	...	...	2	1	...	...	1	...					
20 and under 25.....	35	8	27	10	...	...	...	...	13	21	2	...	2	...	2	...	1	...					
25 and under 30.....	51	3	48	17	...	1	...	...	...	...	...	...	...	...	2	...	...	...					
30 and under 35.....	38	2	36	10	...	...	...	...	1	2	19	...	2	...	2	...	1	...					
35 and under 40.....	25	1	24	6	...	...	...	...	...	1	...	14	3	...	1	...	...	...					
40 and under 45.....	87	7	80	26	...	...	...	1	6	...	...	...	37	3	1	...	...	...					
45 and under 50.....	46	4	42	10	...	...	...	2	...	2	...	...	2	18	...	1	3	...					
50 and under 55.....	92	5	87	17	...	1	...	...	1	2	3	...	...	3	51	1	1	1					
55 and under 60.....	51	1	50	9	...	...	...	...	...	1	1	...	...	1	...	34	...	...					
60 and under 65.....	83	2	81	7	...	...	1	1	...	...	2	...	2	1	8	6	44	3					
65 and under 70.....	40	1	39	1	...	...	...	...	...	1	...	1	...	2	...	...	1	1					
70 and under 75.....	32	...	32	4	...	...	...	...	...	...	...	...	...	...	...	3	1	1					
75 and under 80.....	36	3	33	1	...	...	...	...	...	...	...	...	...	...	...	2	1	4					
80 and under 85.....	62	4	58	5	...	...	...	...	...	...	1	...	...	...	...	1	...	2					
85 and under 90.....	30	2	28	4	...	...	...	...	...	...	...	...	...	...	...	...	1	...					
90 and under 95.....	42	5	37	1	...	...	...	...	...	...	...	...	...	...	...	...	...	2					







TABLE 19

## New York State (Exclusive of New York City)

Study of Medical Care in Welfare Districts, November, 1939

DENIED APPLICATIONS FOR MEDICAL OR HOSPITAL CARE OF PERSONS WITH NON-RELIEF STATUS, CLASSIFIED BY MONTHLY AVERAGE CASH INCOME<sup>1</sup> OF FAMILY DURING ILLNESS AND DURING YEAR PRIOR TO ONSET OF ILLNESS

MONTHLY AVERAGE INCOME DURING YEAR PRIOR TO ONSET OF ILLNESS	Total ap- pli- cations	Not re- ported	MONTHLY AVERAGE INCOME DURING ILLNESS															
			Total	None	Under \$5	\$5 and under \$10	\$10 and under \$15	\$15 and under \$20	\$20 and under \$25	\$25 and under \$30	\$30 and under \$35	\$35 and under \$40	\$40 and under \$45	\$45 and under \$50	\$50 and under \$55	\$55 and under \$60	\$60 and under \$65	\$65 and under \$70
Total.....	512	221	291	53	.....	.....	.....	2	3	3	6	8	7	6	17	2	17	6
Not reported.....	263	213	50	15	.....	.....	.....	.....	2	1	1	1	2	....	3	1	1	1
Reported.....	249	8	241	38	.....	.....	.....	2	1	2	5	7	5	6	14	1	16	5
None.....	22	.....	22	11	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....
Under \$5.....	1	.....	1	1	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....
\$5 and under \$10.....	1	.....	1	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....
\$10 and under \$15.....	1	.....	1	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....
\$15 and under \$20.....	1	.....	1	.....	.....	.....	.....	1	1	.....	.....	.....	.....	.....	.....	.....	.....	.....
\$20 and under \$25.....	4	1	3	1	.....	.....	.....	.....	.....	.....	.....	.....	.....	1	.....	.....	.....	.....
\$25 and under \$30.....	4	.....	4	.....	.....	.....	.....	.....	2	.....	.....	.....	.....	.....	.....	.....	.....	.....
\$30 and under \$35.....	5	.....	5	.....	.....	.....	.....	.....	.....	.....	4	1	.....	.....	.....	.....	.....	.....
\$35 and under \$40.....	2	.....	2	.....	.....	.....	.....	.....	.....	.....	.....	1	.....	.....	.....	.....	.....	.....
\$40 and under \$45.....	10	.....	10	3	.....	.....	.....	.....	.....	.....	.....	1	.....	.....	.....	.....	.....	.....
\$45 and under \$50.....	7	.....	7	2	.....	.....	.....	.....	.....	.....	.....	1	.....	.....	.....	.....	.....	.....
\$50 and under \$55.....	13	.....	13	2	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....
\$55 and under \$60.....	2	.....	2	1	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....
\$60 and under \$65.....	14	.....	14	2	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....
\$65 and under \$70.....	5	.....	5	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....
\$70 and under \$75.....	6	2	4	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....
\$75 and under \$80.....	7	.....	7	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....
\$80 and under \$85.....	15	.....	15	3	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....
\$85 and under \$90.....	11	1	10	1	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....
\$90 and under \$95.....	11	.....	11	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....
\$95 and under \$100.....	4	.....	4	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....

<sup>1</sup> Estimated.<sup>2</sup> Includes application of 1 individual whose relatives provided for living expenses during illness.<sup>3</sup> Includes application of 1 individual whose relatives provided for living expenses.





TABLE 19 — (Concluded)









TABLE 21

New York State (Exclusive of New York City)

Study of Medical Care in Welfare Districts, November, 1939

COMPARISON OF MONTHLY AVERAGE CASH INCOME <sup>1</sup> DURING ILLNESS  
AND DURING YEAR PRIOR TO ONSET OF ILLNESS, OF FAMILIES OF  
APPLICANTS FOR MEDICAL OR HOSPITAL CARE WITH NON-RELIEF  
STATUS

DISPOSITION	Number of applicants <sup>2</sup>	MEDIAN	
		Monthly income during illness	Monthly income during year prior to onset of illness
Total .....	1,547	\$55.82	\$62.04
Approved .....	1,083	53.63	59.35
Denied .....	241	84.32	87.75
Pending at end of month .....	223	51.46	60.94

<sup>1</sup> Estimated.<sup>2</sup> Excludes applicants for whom data were not available.

TABLE 22  
New York State (Exclusive of New York City)  
Study of Medical Care in Welfare Districts, November, 1939  
APPLICANTS FOR MEDICAL OR HOSPITAL CARE WITH NON-RELIEF STATUS, CLASSIFIED BY TYPE AND  
AMOUNT OF ASSET<sup>1</sup>

AMOUNT	NUMBER OF APPLICANTS WITH SPECIFIED ASSET					
	TOTAL			APPROVED		
	Bank account	Insur- ance	Real estate	Farm and garden products	Other <sup>2</sup>	Other <sup>2</sup>
Total reported <sup>3</sup> .....	1,830	1,865	1,802	1,987	1,992	1,364
Applicants without asset.....	1,740	1,204	1,567	1,870	1,926	1,277
Applicants with asset.....	90	661	235	117	66	87
Amount not specified.....	22	425 <sup>4</sup>	86	46	38	31
Under \$25.....	19	3	.....	41	5	33
\$ 25 and under \$ 50.....	10	4	1	16	6	13
50 and under 100.....	10	31	1	10	4	4
100 and under 200.....	4	34	3	4	1	2
200 and under 300.....	3	25	7	.....	.....	.....
300 and under 400.....	2	22	1	.....	.....	.....
400 and under 500.....	2	101	13	.....	.....	.....
500 and under 750.....	1	26	5	.....	.....	.....
750 and under 1,000.....	3	117	36	.....	.....	.....
1,000 and under 2,000.....	3	728	35	.....	.....	.....
2,000 and under 3,000.....	2	75	16	.....	.....	.....
3,000 and under 4,000.....	3	4	14	.....	.....	.....
4,000 and under 5,000.....	1	6	16	.....	.....	.....
5,000 and over.....	.....	.....	.....	.....	.....	.....

<sup>1</sup> Includes assets of applicants or their families.

<sup>2</sup> Includes automobiles, farm supplies and equipment, etc.

<sup>3</sup> Excludes applicants for whom data were not available.

<sup>4</sup> Includes 54 applicants whose insurance was adjusted or was being adjusted (50 approved, 1 denied, and 3 pending), and 12 applicants whose insurance had no cash value (10 approved, 1 denied and 1 pending).

<sup>5</sup> Includes 1 applicant whose insurance had no cash value.

<sup>6</sup> Includes 3 applicants whose insurance had no cash value.

<sup>7</sup> Includes 2 applicants whose insurance had no cash value.



TABLE 22 — (Concluded)

TABLE 23

New York State (Exclusive of New York City)

Study of Medical Care in Welfare Districts, November, 1939

COMPARISON OF MONTHLY BUDGET OF FAMILY USED TO DETERMINE ELIGIBILITY FOR MEDICAL OR HOSPITAL CARE WITH SIZE OF FAMILY OF APPLICANTS WITH NON-RELIEF STATUS

DISPOSITION	Number of applicants <sup>1</sup>	MEDIAN	
		Size of family	Monthly budget
Total.....	1,356	4.3	\$62.74
Approved.....	977	4.3	61.57
Denied.....	194	4.1	69.71
Pending at end of month.....	185	4.5	61.25

<sup>1</sup> Excludes applicants for whom data were not available.

TABLE 24

New York State (Exclusive of New York City)

Study of Medical Care in Welfare Districts, November, 1939

APPLICANTS FOR MEDICAL OR HOSPITAL CARE WITH NON-RELIEF STATUS, CLASSIFIED BY MONTHLY BUDGET OF FAMILY USED TO DETERMINE ELIGIBILITY FOR MEDICAL OR HOSPITAL CARE AND SIZE OF FAMILY

SIZE OF FAMILY	TOTAL		APPROVED		DENIED		PENDING AT END OF MONTH	
	Number of applicants <sup>1</sup>	Median monthly budget	Number of applicants <sup>1</sup>	Median monthly budget	Number of applicants <sup>1</sup>	Median monthly budget	Number of applicants <sup>1</sup>	Median monthly budget
Total applicants.....	1,356	\$62.74	977	\$61.57	194	\$69.71	185	\$61.25
1 person.....	170	25.19	125	24.92	23	27.50	22	25.00
2 persons.....	190	47.31	131	44.58	31	59.38	28	43.75
3 persons.....	245	59.89	172	58.89	40	65.00	33	54.38
4 persons.....	232	65.96	178	63.91	34	70.00	20	82.50
5 persons.....	167	74.50	122	72.50	25	81.25	20	75.00
6 persons.....	128	75.83	88	76.36	16	91.67	24	61.67
7 persons.....	89	95.68	66	96.67	12	92.50	11	82.50
8 persons.....	54	110.71	38	110.00	7	2	9	2
9 persons.....	39	100.83	27	120.83	5	2	7	2
10 persons.....	18	97.50	13	102.50	.....	.....	5	2
11 persons.....	16	96.67	12	112.50	.....	.....	4	2
12 or more persons.....	8	2	5	2	1	2	2	2

<sup>1</sup> Excludes applicants for whom data were not available.<sup>2</sup> Median not significant.





TABLE 26

## New York State (Exclusive of New York City)

Study of Medical Care in Welfare Districts, November, 1939

COMPARISON OF MONTHLY BUDGET USED TO DETERMINE ELIGIBILITY FOR MEDICAL OR HOSPITAL CARE WITH REGULAR MONTHLY RELIEF BUDGET, OF FAMILIES OF APPLICANTS WITH NON-RELIEF STATUS

MONTHLY BUDGET APPLIED FOR ELIGIBILITY FOR MEDICAL CARE ONLY AS COMPARED WITH REGULAR MONTHLY RELIEF BUDGET	TOTAL APPLICANTS		APPROVED		DENIED		PENDING AT END OF MONTH	
	Num- ber	Per- cent	Num- ber	Per- cent	Num- ber	Per- cent	Num- ber	Per- cent
Total applicants.....	2,893	.....	1,714	.....	512	.....	667	.....
Not reported.....	1,498	.....	717	.....	321	.....	460	.....
Reported.....	1,395	100.0	997	100.0	191	100.0	207	100.0
Higher.....	734	52.6	516	51.8	126	66.0	92	44.4
Not Higher.....	661	47.4	481	48.2	65	34.0	115	55.6







TABLE 27 — (Concluded)

REGULAR MONTHLY RELIEF BUDGET	MONTHLY BUDGET APPLIED — (Concluded)														
	\$75 and under \$80	\$80 and under \$85	\$85 and under \$90	\$90 and under \$95	\$95 and under \$100	\$100 and under \$105	\$105 and under \$110	\$110 and under \$115	\$115 and under \$120	\$120 and under \$125	\$125 and under \$130	\$130 and under \$135	\$135 and under \$140	\$140 and under \$145	\$145 and under \$150
Total applicants.....	42	42	32	35	26	32	24	21	16	13	10	12	5	6	16
Not reported.....	3	6	4	2	1	2	2	2	2	.....	.....	2	.....	1	4
Reported.....	39	36	28	33	25	30	22	19	14	13	10	10	5	5	12
\$5 and under \$10.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....
10 and under 15.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....
15 and under 20.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....
20 and under 25.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....
25 and under 30.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....
30 and under 35.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....
35 and under 40.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....
40 and under 45.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....
45 and under 50.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....
50 and under 55.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....
55 and under 60.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....
60 and under 65.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....
65 and under 70.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....
70 and under 75.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....
75 and under 80.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....
80 and under 85.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....
85 and under 90.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....
90 and under 95.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....
95 and under 100.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....
100 and under 105.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....
105 and under 110.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....
110 and under 115.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....
115 and under 120.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....
120 and under 125.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....
125 and under 130.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....
130 and under 135.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....
135 and under 140.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....
140 and under 145.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....
145 and under 150.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....
150 and over.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....

<sup>1</sup> Budget applied includes store rental.

TABLE 28

New York State (Exclusive of New York City)

Study of Medical Care in Welfare Districts, November, 1939

COMPARISON OF AVERAGE MONTHLY BUDGET USED TO DETERMINE ELIGIBILITY FOR MEDICAL OR HOSPITAL CARE WITH AVERAGE MONTHLY RELIEF BUDGET, OF FAMILIES OF APPLICANTS WITH NON-RELIEF STATUS, WHERE THE REGULAR RELIEF BUDGET IS LOWER

DISPOSITION	Number of applicants <sup>1</sup>	AVERAGE <sup>2</sup>	
		Regular monthly relief budget	Monthly budget applied for eligibility for medical care only
Total .....	635	\$57.68	\$74.01
Approved .....	483	57.72	73.67
Denied .....	92	60.00	77.50
Pending at end of month .....	60	54.17	70.00

<sup>1</sup> Excludes applicants for whom data were not available.<sup>2</sup> Expressed as a median.

TABLE 29  
New York State (Exclusive of New York City)  
Study of Medical Care in Welfare Districts, November, 1939  
APPLICANTS FOR MEDICAL OR HOSPITAL CARE WITH NON-RELIEF STATUS, CLASSIFIED BY DIAGNOSTIC  
GROUP AND DISPOSITION

DIAGNOSTIC GROUP	TOTAL		APPROVED		DENIED		PENDING AT END OF MONTH	
	Num- ber	Percent	Num- ber	Percent	Num- ber	Percent	Num- ber	Percent
Total.....	2,893	.....	1,714	.....	512	.....	667	.....
Not reported.....	217	.....	47	.....	30	.....	140	.....
Reported.....	2,676	100.0	1,667	100.0	482	100.0	527	100.0
Infectious diseases.....	212	7.9	144	8.6	33	6.8	35	6.7
Neoplasms.....	102	3.8	62	3.7	16	3.3	24	4.6
Rheumatic diseases, disorders of metabolism and endocrine glands, vitamin deficiencies.....	104	3.9	63	3.8	16	3.3	25	4.7
Traumatic conditions, poisonings.....	330	12.3	154	9.2	94	19.5	82	15.6
Puerperal state.....	337	12.6	229	13.7	60	12.4	48	9.1
Neurological and psychiatric conditions.....	138	5.2	81	4.9	22	4.6	35	6.6
Diseases of the eye and ear.....	63	2.4	48	2.9	9	1.9	6	1.1
Cardio-vascular diseases.....	161	6.0	88	5.3	25	5.2	48	9.1
Blood, splenic, lymphatic diseases.....	29	1.1	18	1.1	6	1.2	5	0.9
Diseases of the respiratory system.....	325	12.1	243	14.6	38	7.9	44	8.4
Diseases of the digestive system.....	379	14.2	242	14.5	64	13.3	73	13.9
Peritoneal and other abdominal conditions, hernia.....	57	2.1	36	2.2	12	2.5	9	1.7
Diseases of the uro-genital system.....	133	5.0	74	4.4	30	6.2	29	5.5
Diseases of skin, cellular tissue.....	91	3.4	70	4.2	10	2.1	11	2.1
Non-traumatic diseases of bones and organs of movement.....	48	1.8	23	1.4	9	1.9	16	3.0
Conditions not elsewhere classified.....	167	6.2	92	5.5	38	7.9	37	7.0



TABLE 30  
New York State (Exclusive of New York City)  
Study of Medical Care in Welfare Districts, November, 1939  
APPLICANTS FOR MEDICAL OR HOSPITAL CARE WITH NON-RELIEF STATUS, CLASSIFIED BY DIAGNOSTIC  
GROUP AND SOURCE OF DIAGNOSIS

DIAGNOSTIC GROUP	Total	Not reported	SOURCE OF DIAGNOSIS					Status of physician unknown	Other <sup>1</sup>
			Total	Private physician	City physician	Hospital or clinic physician			
Total.....	2,893	346	2,547	264	160	1,245	863	15	
Not reported.....									
Reported.....	217	170	47	8	1	23	15		
Infectious diseases.....	2,676	176	2,500	256	159	1,222	848	15	
Neoplasms.....	212	14	198	23	18	98	59		
Rheumatic diseases, disorders of metabolism and endocrine glands, vitamin deficiencies.....	102	3	99	9	1	46	43		
Traumatic conditions, poisonings.....	104	5	99	12	7	45	35		
Puerperal state.....	330	16	314	29	7	205	71	2	
Neurological and psychiatric conditions.....	337	18	319	29	9	151	130		
Diseases of the eye and ear.....	138	14	124	13	6	63	39	3	
Cardio-vascular diseases.....	63	4	59	7	3	27	19		
Blood, splenic, lymphatic diseases.....	161	7	154	18	3	65	68		
Diseases of the respiratory system.....	29	1	28	4	1	13	10		
Diseases of the digestive system.....	325	15	310	28	61	135	84	2	
Peritoneal and other abdominal conditions, hernia.....	379	29	350	40	14	149	139	8	
Diseases of the uro-genital system.....	57	5	52	4	1	31	16		
Diseases of skin, cellular tissue.....	133	3	130	18	8	63	41		
Non-traumatic diseases of bones and organs of movement.....	91	8	83	7	3	37	36		
Conditions not elsewhere classified.....	48	3	45	4	3	27	11		
	167	31	136	11	11	67	47		

<sup>1</sup> Includes dentist, school nurse, public school dental hygienist, city court and police emergency.

TABLE 31

New York State (Exclusive of New York City)

Study of Medical Care in Welfare Districts, November, 1939

TYPE OF CARE REQUESTED AND AUTHORIZED FOR APPLICANTS  
APPROVED FOR MEDICAL OR HOSPITAL CARE, WITH NON-RELIEF  
STATUS

TYPE OF CARE	REQUESTING SPECIFIED CARE		AUTHORIZED FOR SPECIFIED CARE	
	Number	Percent	Number	Percent
Total.....	1,714	.....	1,714	.....
Not reported.....	22		30	
Reported.....	<sup>1</sup> 1,692	<sup>1</sup> 100.0	<sup>1</sup> 1,684	<sup>1</sup> 100.0
Medical care.....	<sup>1</sup> 665	<sup>1</sup> 39.3	<sup>1</sup> 630	<sup>1</sup> 37.4
Physician.....	<sup>1</sup> 572	<sup>1</sup> 33.8	<sup>1</sup> 542	<sup>1</sup> 32.2
General practitioner.....	<sup>1</sup> 239	<sup>1</sup> 14.1	<sup>1</sup> 207	<sup>1</sup> 12.3
Office.....	106	6.3	104	6.2
Home.....	139	8.2	112	6.7
Specialist.....	21	1.3	22	1.3
Office.....	20	1.2	21	1.2
Home.....	1	0.1	1	0.1
Obstetrical care.....	229	13.5	227	13.5
Home.....	24	1.4	30	1.8
Hospital.....	205	12.1	197	11.7
Other special services by physician.....	109	6.4	113	6.7
Dental care.....	<sup>1</sup> 30	<sup>1</sup> 1.8	<sup>1</sup> 30	<sup>1</sup> 1.8
Extractions.....	22	1.3	21	1.2
Other.....	11	0.7	13	0.8
Nursing care.....	14	0.8	12	0.7
Registered nurse.....	11	0.6	10	0.6
Nurse housekeeper.....	3	0.2	2	0.1
Drugs.....	36	2.1	35	2.1
Appliances.....	16	0.9	15	0.9
Clinic care.....	45	2.7	47	2.8
Other.....	2	0.1	2	0.1
Hospital care (other than obstetrical care).....	1,119	66.1	1,133	67.3

<sup>1</sup> This total does not equal the sum of the individual items since some persons requested or were authorized to receive more than one type of care.

TABLE 32

New York State (Exclusive of New York City)

Study of Medical Care in Welfare Districts, November, 1939

APPROVED APPLICATIONS FOR MEDICAL OR HOSPITAL CARE OF PERSONS WITH NON-RELIEF STATUS, CLASSIFIED BY DIAGNOSTIC GROUP AND ABILITY OF FAMILY TO PAY FOR MEDICAL OR HOSPITAL CARE

DIAGNOSTIC GROUP	FAMILY, PRIOR TO APPLICATION, PAID FOR MEDICAL OR HOSPITAL CARE IN CONNECTION WITH THIS ILLNESS					FAMILY TO REPAY COST OF MEDICAL OR HOSPITAL CARE AUTHORIZED					
	Total applications	Not re-reported	REPORTED		Total applications	Not re-reported	REPORTED				
			Total	Paid			Total	To repay	Not re-reported		
				Number						Percent	Number
Total	1,714	159	1,555	311	20.0	1,714	164	184	11.9	43	20
Not reported	47	9	38	5	13.2	47	6	7	17.1	1	.....
Reported	1,667	150	1,517	306	20.2	1,667	158	177	11.7	42	20
Infectious diseases	144	14	130	19	14.6	144	13	12	9.2	4	7
Neoplasms	62	4	58	20	34.5	62	6	8	14.3	6	1
Rheumatic diseases, disorders of metabolism and endocrine glands, vitamin deficiencies	63	7	56	21	37.5	63	9	6	11.1	5	1
Traumatic conditions, poisonings	154	13	141	17	12.1	154	18	24	17.6	3	1
Puerperal state	229	16	213	30	14.1	229	28	25	12.4	15	9
Neurological and psychiatric conditions	81	7	74	30	40.5	81	7	8	10.8	7	1
Diseases of the eye and ear	48	4	44	5	11.4	48	5	3	7.0	1	.....
Cardio-vascular diseases	88	4	84	26	31.0	88	4	7	8.3	1	.....
Blood, splenic, lymphatic diseases	18	1	17	5	29.4	18	1	2	11.8	1	.....
Diseases of the respiratory system	243	20	214	31	14.5	243	26	21	9.7	12	4
Diseases of the digestive system	242	25	217	46	21.2	242	17	27	12.0	19	3
Peritoneal and other abdominal conditions, hernias	36	3	33	3	9.1	36	2	4	11.8	2	1
Diseases of the uro-genital system	74	6	68	17	25.0	74	6	7	10.3	2	1
Diseases of skin, cellular tissue	70	4	66	13	19.7	70	8	6	9.7	4	1
Non-traumatic diseases of bones and organs of movement	23	4	19	9	47.4	23	1	3	13.6	2	.....
Conditions not elsewhere classified	92	9	83	14	16.9	92	7	14	16.5	3	.....



TABLE 33  
New York State (Exclusive of New York City)  
Study of Medical Care in Welfare Districts, November, 1939  
DENIED APPLICATIONS FOR MEDICAL OR HOSPITAL CARE OF PERSONS WITH NON-RELIEF STATUS,  
CLASSIFIED BY DIAGNOSTIC GROUP AND TYPE OF CARE REQUESTED

DIAGNOSTIC GROUP	Total appli- cations	Not re- ported	TYPE OF CARE REQUESTED					
			MEDICAL CARE		HOSPITAL CARE		MEDICAL AND HOSPITAL CARE	
			Number	Percent	Number	Percent	Number	Percent
Total.....	512	24	488					
Not reported.....		24					8	1.6
Reported.....	30	6	24					
Infectious diseases.....	482	18	464					
Neoplasms.....	33	1	32				8	1.7
Rheumatic diseases, disorders of metabolism and endocrine glands, vitamin deficiencies.....	16	1	15				1	3.1
Traumatic conditions, poisonings.....	16		16					
Puerperal state.....	94	3	91				2	12.5
Neurological and psychiatric conditions.....	60	1	59				1	1.1
Diseases of the eye and ear.....	22		22				2	3.4
Cardio-vascular diseases.....	9		9					
Blood, splenic, lymphatic diseases.....	25		25					
Diseases of the respiratory system.....	38		38					
Diseases of the digestive system.....	64	3	61					
Peritoneal and other abdominal conditions, hernias.....	12	4	8					
Diseases of the uro-genital system.....	30	1	29				2	3.3
Diseases of the skin, cellular tissue.....	10	1	9					
Non-traumatic diseases of bones and organs of movement.....	9		9					
Conditions not elsewhere classified.....	38	2	36					

(1) Base too small for computing percentages.

TABLE 34  
 New York State (Exclusive of New York City)  
 Study of Medical Care in Welfare Districts, November, 1939  
 PENDING APPLICATIONS FOR MEDICAL OR HOSPITAL CARE OF PERSONS WITH NON-RELIEF STATUS,  
 CLASSIFIED BY DIAGNOSTIC GROUP AND TYPE OF CARE REQUESTED

DIAGNOSTIC GROUP	Total appli- cations	Not re- ported	TYPE OF CARE REQUESTED					
			MEDICAL CARE		HOSPITAL CARE		MEDICAL AND HOSPITAL CARE	
			Number	Percent	Number	Percent	Number	Percent
Total.....	667	199	468	3.0	436	93.2	18	3.8
Not reported.....	140	124	16	3	13	81.3	.....	.....
Reported.....	527	75	452	11	423	93.6	18	4.0
Infectious diseases.....	35	4	31	.....	30	96.8	1	3.2
Neoplasms.....	24	3	21	.....	21	100.0	.....	.....
Rheumatic diseases, disorders of metabolism and endocrine glands, vitamin deficiencies.....	25	4	21	1	19	90.4	1	4.8
Traumatic conditions, poisonings.....	82	12	70	2	65	92.8	3	4.3
Puerperal state.....	48	6	42	.....	42	100.0	.....	.....
Neurological and psychiatric conditions.....	35	4	31	.....	31	100.0	.....	.....
Diseases of the eye and ear.....	46	11	35	.....	34	(1)	1	(1)
Cardio-vascular diseases.....	48	1	37	1	35	94.6	1	2.7
Blood, aplenic, lymphatic diseases.....	5	1	4	.....	4	100.0	.....	.....
Diseases of the respiratory system.....	44	7	37	.....	34	91.9	3	8.1
Diseases of the digestive system.....	73	11	62	2	56	90.3	4	6.5
Peritoneal and other abdominal conditions, hernias.....	9	1	8	.....	7	(1)	1	(1)
Diseases of the uro-genital system.....	29	4	25	1	22	88.0	2	8.0
Diseases of skin, cellular tissue.....	11	2	9	.....	9	100.0	.....	.....
Non-traumatic diseases of bones and organs of movement.....	16	.....	16	.....	15	93.7	1	6.3
Conditions not elsewhere classified.....	37	4	33	12.1	29	87.9	.....	.....

(1) Base too small for computing percentages.

TABLE 35  
New York State (Exclusive of New York City)  
Study of Medical Care in Welfare Districts, November, 1939  
DENIED APPLICATIONS FOR MEDICAL OR HOSPITAL CARE OF PERSONS WITH NON-RELIEF STATUS,  
CLASSIFIED BY TYPE OF CARE REQUESTED AND REASON FOR DENIAL

TYPE OF CARE REQUESTED	Total appli- ca- tions denied	Not re- ported	REASON FOR DENIAL											Care available at a public or private medical agency	Private physi- cian will treat	With- drawn	Other
			FAMILY CONSIDERED ABLE TO PAY FOR OWN MEDICAL CARE														
			Total	Through own resources				Through assist- ance of legally responsible rela- tives outside of household	Through other means <sup>1</sup>	Not re- ported							
				Total	In- come	Assets	Not re- ported										
Total.....	512	3	509	352	309	194	60	55	7	33	3	28	1	80	48		
Not reported.....	24	2	22	15	14	9	1	4			1	3	1		3		
Reported.....	488	1	487	337	295	185	59	51	7	33	2	25		80	45		
Physician.....	68		68	49	45	31	5	9	1	2	1	4		12	3		
General practitioner.....	5		5	3	2	2			1					1			
Office.....	4		4	2	1	1			1					1			
Home.....	1		1	1	1	1											
Specialist.....	1		1														
Office.....	1		1														
Home.....	1		1														
Obstetrical care.....	58		58	45	42	28	5	9									
Home.....	1		1	1													
Hospital.....	57		57	44	42	28	5	9									
Other special services by physician.....	4		4	1	1	1											
Dental care.....	2		2	2	2	2											
Extractions.....	1		1	1	1	1											
Other.....	1		1	1	1	1											

<sup>1</sup> Includes the following: accident case in hands of attorney for collection of damages, person or company responsible for accident to pay bill, compensation insurance of employer, loan from employer, etc.



TABLE 35 — (Concluded)

TYPE OF CARE REQUESTED	Total appli- cations denied	Not re- ported	REASON FOR DENIAL										Care available at a public or private medical agency	Private physi- cian will treat	With- drawn	Other
			FAMILY CONSIDERED ABLE TO PAY FOR OWN MEDICAL CARE													
			Total	Through own resources				Through assist- ance of legally responsible rela- tives outside of household	Through other means <sup>1</sup>	Not re- ported						
				Total	In- come	Assets	Not re- ported									
Reported — (Concluded)																
Nursing care.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....
Registered nurse.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....
Nurse housekeeper.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....
Drugs.....	5	.....	5	4	4	4	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....
Appliances.....	2	.....	2	2	2	2	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....
Clinic care.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....
Other medical care.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....
Hospital care (other than obstetrical care).....	400	1	399	272	234	140	52	42	6	31	1	20	.....	.....	66	41
General practitioner (office) and obstetrical care (hospital).....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....
General practitioner (home) and obstetrical care (home).....	1	.....	1	1	1	1	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....
General practitioner (home) and dental care (other than extractions).....	1	.....	1	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	1
General practitioner (home) and hospital care (other than obstetrical care).....	1	.....	1	1	1	1	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....
General practitioner (home) and obstetrical care (other than obstetrical care).....	2	.....	2	2	2	2	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....
Obstetrical care (hospital) and clinic care.....	1	.....	1	1	1	1	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....
Other special services by physician and hos- pital care (other than obstetrical care).....	3	.....	3	3	3	1	2	.....	.....	.....	.....	.....	.....	.....	.....	.....
Clinic care and hospital care (other than obstetrical care).....	1	.....	1	.....	.....	.....	.....	.....	.....	.....	.....	1	.....	.....	.....	.....
Specialist (office), dental care (extractions and other), appliances, and other medical care.....	1	.....	1	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	1	.....

<sup>1</sup> Includes the following: accident case in hands of attorney for collection of damages, person or company responsible for accident to pay bill, compensation insurance of employer, loan from employer, etc.

TABLE 36

New York State (Exclusive of New York City)

Study of Medical Care in Welfare Districts, November, 1939

APPLICATIONS FOR MEDICAL OR HOSPITAL CARE OF PERSONS WITH NON-RELIEF STATUS, CLASSIFIED BY DIAGNOSIS AND TYPE OF CARE REQUESTED<sup>1</sup>

DIAGNOSIS	TOTAL					APPROVED				
	Total	Medical care	Hospital care	Medical and hospital care	Not reported	Total	Medical care	Hospital care	Medical and hospital care	Not reported
Total.....	2,893	391	2,135	114	253	1,714	354	1,242	88	30
Not reported.....	217	16	61	1	139	47	11	26	1	9
Reported.....	2,676	375	2,074	113	114	1,667	343	1,216	87	21
Infectious diseases.....	212	54	145	6	7	144	53	85	4	2
Tuberculosis of the respiratory system.....	60	3	54	1	2	30	3	27	.....	.....
All other forms of tuberculosis.....	4	.....	4	.....	.....	4	.....	4	.....	.....
Syphilis, all forms.....	12	8	4	.....	.....	9	8	1	.....	.....
Gonorrhea, all forms.....	13	2	11	.....	.....	9	1	8	.....	.....
Influenza (grippe), common cold.....	37	27	9	1	.....	33	27	5	1	.....
Acute poliomyelitis, poliomyelitis.....	45	1	39	2	3	26	1	23	1	1
All other general infections and diseases due to higher plant and animal parasites.....	41	13	24	2	2	33	13	17	2	1
Neoplasms.....	102	10	83	4	5	62	10	47	4	1
Malignant neoplasm of the digestive system.....	11	.....	9	.....	2	6	.....	6	.....	.....
Malignant neoplasm of the female genital system and breast.....	16	1	12	2	1	10	1	7	2	.....
All other malignant neoplasm.....	30	6	23	.....	1	18	6	12	.....	.....
Nonmalignant neoplasm of the digestive system.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....
Nonmalignant neoplasm of the female genital system and breast.....	18	.....	17	1	.....	12	.....	11	1	.....
All other nonmalignant neoplasm.....	3	.....	3	.....	.....	2	.....	2	.....	.....
Malignancy unknown, neoplasm of the digestive system.....	2	1	1	.....	.....	1	.....	.....	.....	.....
Malignancy unknown, neoplasm of the female genital system and breast.....	8	.....	7	1	.....	4	.....	3	1	.....
Malignancy unknown, all other neoplasm.....	14	2	11	.....	1	9	2	6	.....	1

<sup>1</sup> The type of care authorized is indicated for approved applications.





Cardio-vascular diseases.....	161	25	121	4	11	88	24	61	3
Cardiac diseases.....	122	15	95	4	8	67	14	50	3
General arteriosclerosis.....	9	5	8	.....	.....	3	.....	3	.....
Other arterial diseases.....	15	.....	9	.....	1	8	5	3	.....
Varices.....	14	5	7	.....	2	10	5	5	.....
All other venous and capillary diseases.....	2	.....	2	.....	.....	.....	.....	.....	.....
Blood, splenic, lymphatic diseases.....	29	3	25	.....	1	18	3	15	.....
Peripartous anemia.....	2	.....	2	.....	.....	2	.....	2	.....
All other diseases of the hemic.....	13	3	10	.....	.....	10	3	7	.....
Acute lymphadenitis, abscess of lymph-nodes.....	5	.....	5	.....	.....	4	.....	4	.....
All other diseases of the lymphatic system.....	9	.....	8	.....	1	2	.....	2	.....
Diseases of the respiratory system.....	325	65	217	29	14	243	65	148	4
Infectious hypertrophy of tonsil, adenoid.....	160	47	95	17	1	130	47	67	16
Sinusitis.....	29	1	4	.....	.....	3	1	2	.....
All other diseases of the upper respiratory tract.....	5	5	10	2	3	26	5	18	1
Broncho-pneumonia.....	27	.....	14	.....	.....	3	.....	2	.....
Lobar-pneumonia.....	16	.....	14	.....	2	5	2	5	.....
Pneumonia, unspecified.....	59	2	40	5	3	36	2	30	1
All other forms of pneumonia.....	1	1	.....	.....	.....	.....	1	.....	.....
Chronic bronchitis.....	4	.....	.....	.....	.....	4	.....	4	.....
Bronchial asthma.....	23	7	14	1	1	19	7	11	1
Pleural conditions.....	14	1	10	.....	3	11	1	8	1
All other diseases of the lower respiratory tract.....	7	1	4	1	1	5	1	2	1
Diseases of the digestive system.....	379	52	286	23	18	242	47	175	3
Diseases of teeth and gums.....	43	29	10	3	1	36	26	7	8
Other diseases of mouth and pharynx.....	3	.....	3	.....	.....	3	.....	.....	.....
Ulcer of stomach and duodenum.....	37	4	31	.....	.....	19	3	15	1
Gastro-enteritis, colitis, colitis ulcerosa.....	19	1	16	1	1	12	1	10	1
Appendicitis.....	173	9	140	13	11	101	9	83	1
Hemorrhoids.....	10	1	9	.....	.....	6	1	5	.....
All other conditions of rectum and anus.....	16	.....	19	.....	.....	13	.....	13	.....
All other diseases of the gastro-intestinal tract and pancreas.....	18	2	13	2	1	15	2	10	2
Cirrhosis of liver.....	5	.....	5	.....	.....	4	.....	4	.....
Other liver diseases.....	2	1	1	.....	.....	1	.....	.....	.....
Diseases of the bile passage.....	53	5	42	4	2	32	4	25	3
Peritoneal and other abdominal conditions, hernias.....	57	3	49	1	4	36	3	31	2
Peritoneal adhesions.....	1	.....	1	.....	.....	1	.....	1	.....
Other conditions of the abdominal cavity.....	8	.....	7	.....	.....	7	.....	6	.....
Hernia.....	48	3	41	1	3	28	3	24	1

TABLE 36—(Continued)

DIAGNOSIS	TOTAL					APPROVED				
	Total	Medical care	Hospital care	Medical and hospital care	Not re-ported	Total	Medical care	Hospital care	Medical and hospital care	Not re-ported
Reported — (Continued)										
Diseases of the uro-genital system.....	133	10	113	5	5	74	7	64	3	.....
Diseases of the kidney parenchyma.....	27	3	24	.....	.....	17	3	14	.....	.....
Calculus in the urinary system.....	3	.....	3	.....	.....	2	.....	2	.....	.....
All other diseases of the urinary system.....	29	2	23	1	3	14	1	13	.....	.....
Benign hypertrophy of prostate.....	6	.....	6	.....	.....	3	.....	3	.....	.....
All other diseases of the male genital system.....	5	.....	4	1	.....	2	.....	1	1	.....
Phimosis.....	7	1	6	.....	.....	4	.....	4	.....	.....
Salpingitis, oöphoritis.....	13	1	11	1	.....	7	.....	6	1	.....
Diseases of uterus and cervix.....	14	.....	11	2	1	9	.....	8	1	.....
Displacement of uterus, rectocele, cystocele.....	11	.....	10	.....	1	4	.....	4	.....	.....
Vulvitis, vaginitis.....	1	1	.....	.....	.....	1	1	.....	.....	.....
All other non-puerperal diseases of the female genital system.....	17	2	15	.....	.....	11	2	9	.....	.....
Non-puerperal diseases of the female breast.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....
Diseases of skin, cellular tissue.....	91	20	62	5	4	70	20	44	5	1
Furuncle, furunculosis, carbunculus, cellulitis, superficial ulcer.....	71	13	50	5	3	55	13	36	5	1
Other infections and infestations of skin.....	14	6	8	.....	.....	11	6	5	.....	.....
All other diseases of skin.....	6	1	4	.....	1	4	1	3	.....	.....
Non-traumatic diseases of bones and organs of movement.....	48	3	43	2	.....	23	3	19	1	.....
Osteomyelitis.....	19	.....	19	.....	.....	10	.....	10	.....	.....
Other infections of the musculo-skeletal system.....	2	.....	2	.....	.....	2	.....	2	.....	.....
Orthopedic defect for correction.....	24	2	20	2	.....	9	2	6	1	.....
All other conditions of the musculo-skeletal system.....	3	1	2	.....	.....	2	1	1	.....	.....
Conditions not elsewhere classified.....	167	29	130	2	6	92	16	74	2	.....
for diagnosis only.....	47	4	40	1	2	29	3	25	1	.....
Undiagnosed conditions.....	108	14	89	1	4	58	9	48	1	.....
Not ill.....	12	11	1	.....	.....	5	4	1	.....	.....

<sup>1</sup> All but 2 required prosthesis only.





TABLE 36—(Continued)

DIAGNOSIS	DENIED				PENDING AT END OF MONTH			
	Total	Medical care	Hospital care	Medical and hospital care	Not reported	Total	Medical care	Hospital care
<b>Reported — (Continued)</b>								
Traumatic conditions, poisonings.....	94	3	87	1	3	82	2	65
Traumatic fractures.....	43	2	39	1	1	40	2	27
All other traumatic conditions.....	44	1	41	2	2	36	.....	34
Poisonings including alcoholism.....	7	.....	7	.....	.....	6	.....	4
<b>Puerperal state.....</b>	60	2	55	2	1	48	.....	42
Pregnancy without indication of obstetrical complications, delivered.....	46	2	41	2	1	41	.....	37
Pregnancy with obstetrical complications.....	2	.....	2	.....	.....	3	.....	3
Abortion.....	12	.....	12	.....	.....	4	.....	2
Pregnancy, outcome unknown, including untermi- nated pregnancy.....	.....	.....	.....	.....	.....	.....	.....	.....
<b>Neurological and psychiatric conditions.....</b>	22	.....	22	.....	.....	35	.....	31
Vascular cerebral accident.....	7	.....	7	.....	.....	7	.....	7
All other conditions of the nervous system in general.....	5	.....	5	.....	.....	3	.....	3
Psychiatric conditions.....	10	.....	10	.....	.....	25	.....	21
<b>Diseases of the eye and ear.....</b>	9	.....	9	.....	.....	6	.....	4
Cataract and glaucoma.....	1	.....	1	.....	.....	1	.....	1
All other diseases of the ophthalmic system.....	7	.....	7	.....	.....	4	.....	1
Mastoiditis and otitis media.....	1	.....	1	.....	.....	1	.....	1
All other diseases of the auditory system.....	.....	.....	.....	.....	.....	.....	.....	.....
<b>Cardio-vascular diseases.....</b>	25	.....	25	.....	.....	48	1	35
Cardiac diseases.....	18	.....	18	.....	.....	37	1	27
General arteriosclerosis.....	.....	.....	.....	.....	.....	5	.....	5
Other arterial diseases.....	4	.....	4	.....	.....	3	.....	2
Varices.....	1	.....	1	.....	.....	1	.....	1
All other venous and capillary diseases.....	2	.....	2	.....	.....	3	.....	1

[illegible]

TABLE 36—(Concluded)

DIAGNOSIS	DENIED					PENDING AT END OF MONTH				
	Total	Medical care	Hos- pital care	Medical and hospital care	Not re- ported	Total	Medical care	Hos- pital care	Medical and hospital care	Not re- ported
Reported — ( <i>Concluded</i> )										
Diseases of skin, cellular tissue.....	10	.....	9	.....	1	11	.....	9	.....	2
Furuncle, furunculosis, carbunculus, cellulitis, superficial ulcer.....	7	.....	7	.....	.....	9	.....	7	.....	2
Other infections and infestations of skin.....	2	.....	2	.....	.....	1	.....	1	.....	.....
All other diseases of skin.....	1	.....	.....	.....	1	1	.....	1	.....	.....
Non-traumatic diseases of bones and organs of movement.....	9	.....	9	.....	.....	16	.....	15	1	.....
Osteomyelitis.....	3	.....	3	.....	.....	6	.....	6	.....	.....
Other infections of the musculo-skeletal system.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....
Orthopedic defect for correction.....	6	.....	6	.....	.....	9	.....	8	1	.....
All other conditions of the musculo-skeletal system.....	.....	.....	.....	.....	.....	1	.....	1	.....	.....
Conditions not elsewhere classified.....	38	9	27	.....	2	37	4	29	.....	4
For diagnosis only.....	12	.....	10	.....	2	6	1	5	.....	.....
Undiagnosed conditions.....	22	5	17	.....	.....	28	.....	24	.....	4
Not ill.....	4	4	.....	.....	.....	3	3	.....	.....	.....

<sup>1</sup> All but 2 required prosthesis only.



TABLE 37

New York State (Exclusive of New York City)

Study of Medical Care in Welfare Districts, November, 1939

APPLICATIONS FOR MEDICAL OR HOSPITAL CARE OF PERSONS WITH  
NON-RELIEF STATUS, CLASSIFIED BY DISPOSITION AND PERSON  
RESPONSIBLE FOR CONSIDERATION OF APPLICATION

PERSON RESPONSIBLE FOR CONSIDERATION OF APPLICATION	TOTAL		APPROVED		DENIED		PENDING AT END OF MONTH	
	Num- ber	Percent	Num- ber	Percent	Num- ber	Percent	Num- ber	Percent
Total.....	2,893	.....	1,714	.....	512	.....	667	.....
Not reported.....	181	.....	90	.....	26	.....	65	.....
Reported.....	2,712	100.0	1,624	100.0	486	100.0	602	100.0
Director of hospital department..	36	1.3	.....	.....	.....	.....	36	6.0
Director of hospital investigations	23	0.9	18	1.1	5	1.0	.....	.....
Medical case work supervisor....	76	2.8	41	2.5	23	4.7	12	2.0
Chief medical worker.....	86	3.2	79	4.9	1	0.2	6	1.0
Hospital social worker.....	96	3.5	60	3.7	16	3.3	20	3.3
Medical social worker.....	128	4.7	49	3.0	26	5.4	53	8.8
Hospitalization clerk.....	1	.1	1	0.1	.....	.....	.....	.....
Medical clerk.....	22	0.8	19	1.2	2	0.4	1	0.2
Out-patient clinic.....	1	.1	1	0.1	.....	.....	.....	.....
Health nurse.....	32	1.2	32	2.0	.....	.....	.....	.....
School nurse.....	6	0.2	6	0.4	.....	.....	.....	.....
Registered nurse.....	78	2.9	78	4.8	.....	.....	.....	.....
Clinic registrar.....	7	0.3	7	0.4	.....	.....	.....	.....
Commissioner.....	124	4.6	106	6.5	7	1.4	11	1.8
Deputy Commissioner.....	73	2.7	56	3.4	13	2.7	4	0.7
Public welfare officer.....	262	9.7	242	14.9	9	1.9	11	1.8
Welfare collector.....	45	1.7	14	0.9	10	2.1	21	3.5
Bureau of investigation.....	51	1.9	24	1.5	3	0.6	24	4.0
Executive director.....	30	1.1	13	0.8	4	0.8	13	2.2
Administrative officer.....	31	1.1	31	1.9	.....	.....	.....	.....
Case supervisor.....	73	2.7	49	3.0	7	1.4	17	2.8
Assistant case supervisor.....	20	0.7	8	0.5	7	1.4	5	0.8
Intake supervisor.....	27	1.0	17	1.0	10	2.1	.....	.....
Case worker.....	1,185	43.7	571	35.2	297	61.1	317	52.6
Intake worker.....	168	6.2	73	4.5	45	9.3	50	8.3
Intake secretary.....	9	0.3	9	0.5	.....	.....	.....	.....
Information clerk.....	22	0.8	20	1.2	1	0.2	1	0.2

<sup>1</sup> Less than one-tenth of one percent.

TABLE 38

New York State (Exclusive of New York City)  
Study of Medical Care in Welfare Districts, November, 1939  
PERSONS WITH RELIEF STATUS AUTHORIZED TO RECEIVE  
MEDICAL OR HOSPITAL CARE, CLASSIFIED BY AGE AND SEX <sup>1</sup>

AGE	TOTAL		MALE		FEMALE	
	Num-ber	Per-cent	Num-ber	Per-cent	Num-ber	Per-cent
Total.....	2 38,494	100.0	17,503	100.0	20,991	100.0
Under 1 year.....	830	2.1	436	2.5	394	1.9
1 year and under 2 years.....	734	1.9	379	2.2	355	1.7
2 years and under 5.....	1,577	4.1	833	4.8	744	3.5
5 years and under 10.....	2,686	7.0	1,381	7.9	1,305	6.2
10 years and under 15.....	2,732	7.1	1,287	7.3	1,445	6.9
15 years and under 20.....	2,156	5.6	939	5.4	1,217	5.8
20 years and under 25.....	1,530	4.0	539	3.1	991	4.7
25 years and under 35.....	3,620	9.4	1,305	7.4	2,315	11.0
35 years and under 45.....	4,498	11.7	1,821	10.4	2,677	12.8
45 years and under 55.....	4,610	12.0	2,242	12.8	2,368	11.3
55 years and under 65.....	3,708	9.6	1,839	10.5	1,869	8.9
65 years and over.....	9,813	25.5	4,502	25.7	5,311	25.3

<sup>1</sup> Based on reports of 75 districts.<sup>2</sup> Excludes 2,178 persons for whom data were not available.

TABLE 39

New York State (Exclusive of New York City)  
Study of Medical Care in Welfare Districts, November, 1939  
AUTHORIZATIONS AND PERSONS WITH RELIEF STATUS AUTHORIZED  
TO RECEIVE MEDICAL OR HOSPITAL CARE, CLASSIFIED BY TYPE OF  
CARE AUTHORIZED <sup>1</sup>

TYPE OF CARE	AUTHORIZATIONS		PERSONS	
	Number	Percent	Number	Percent
Total.....	65,290	.....	40,672	.....
Not reported.....	381	.....	91	.....
Reported.....	64,909	100.0	2 40,581	2 100.0
Medical care.....	2 61,374	2 94.6	2 37,215	2 91.7
Physician.....	27,521	42.3	2 20,182	2 49.7
General practitioner.....	2 25,130	2 38.7	2 18,295	2 45.1
Office.....	10,488	16.2	7,716	19.0
Home.....	14,646	22.6	10,701	26.4
Specialist.....	1,200	1.8	982	2.4
Office.....	1,018	1.5	948	2.3
Home.....	182	0.3	34	0.1
Obstetrical care.....	496	0.8	465	1.1
Home.....	164	0.3	164	0.4
Hospital.....	332	0.5	301	0.7
Other special services by physician.....	695	1.0	596	1.5
Dental care.....	2 2,601	2 4.0	2 2,247	2 5.5
Extractions.....	1,498	2.3	1,272	3.1
Other.....	1,183	1.8	1,062	2.6
Nursing care.....	1,044	1.6	728	1.8
Registered nurse.....	753	1.2	467	1.2
Nurse housekeeper.....	291	0.4	261	0.6
Drugs.....	17,276	26.6	11,578	28.5
Appliances.....	2,879	4.4	2,723	6.7
Clinic care.....	9,849	15.2	6,353	15.7
Other.....	396	0.6	467	1.2
Hospital care (other than obstetrical care).....	3,535	5.4	3,399	8.4

<sup>1</sup> Based on reports of 75 districts.<sup>2</sup> This total does not equal the sum of the individual items since some persons were authorized to receive more than one type of care.

## Chapter IA

### PHYSICAL CONDITION OF PERSONS ADMITTED TO COUNTY HOMES

#### Method of Study and Summary

This report is based on a study made of the first admission forms (PH 1) submitted to the State Department of Social Welfare by 62 city and county homes for the year ending December 31, 1938.

Form PH 1<sup>1</sup> is divided into three sections. The first section consists of general information, such as name, date of admission, record number, last residence, age, sex, color, religion, birthplace, length of time in the United States, New York State and county, civil status, education, occupation and birthplace of parents. The second section contains a record of information relative to the physical examination<sup>2</sup> given the inmate upon admission and consists of diagnosis, appraisal of ability to work, and reason for admission. Section 3 consists of previous care (if any) given inmate in either public home or other public or private institution.

There were 13,570 residents in public homes for the year ending December 31, 1938, of which 6,007 were first admissions, indicating a turnover in public home population of 44.3 percent. The total number of admissions for year was 10,511 persons. The difference between the total number of admissions for the year and the number of first admissions, namely 4,504, represents re-admitted cases. There was a total of 4,276 male and 1,731 female first admissions, an approximate ratio of three males to one female.

Of the 6,007 cases reviewed 5,982 indicated a reason for admission. The most common reason for admission was age or chronic disability. This category represented 3,151 cases, or 52.7 percent of the total number of cases reported. Next in size was the group requiring temporary medical care. This group consisted of 1,772 cases, or 29.6 per cent of the number of cases reported. The remaining group of 1,059 cases, or 17.7 percent were cases using the public homes as temporary shelters pending the securing of employment. It is interesting to note that of the total number of cases reporting reasons for admission 4,923, or 82.3 percent, were admitted for either age or medical attention, while only 17.7 percent were not in need of medical care. Another interesting fact is that New York City with population of 55.1 percent<sup>3</sup> of the total population for the State had only 755, or 12.6 percent, first admissions, whereas the upstate area with 44.9 percent<sup>3</sup> of the population had 5,252, or 87.4 percent of the total number of first admissions. One conclusion which may be deduced from this

<sup>1</sup> See Appendix D, page 449.

<sup>2</sup> Public Welfare Law, Article 11, § 94.

<sup>3</sup> Federal Census of 1930.



TABLE 40  
 PERSONS ADMITTED FOR THE FIRST TIME TO PUBLIC HOMES IN THE YEAR ENDING DECEMBER 31, 1938,  
 CLASSIFIED BY REASON FOR ADMISSION AND BY AGE

ITEM	NEW YORK STATE				NEW YORK CITY				UPSTATE			
	Total	Under 16 years	16 to 64 years	65 years and over	Total	Under 16 years	16 to 64 years	65 years and over	Total	Under 16 years	16 to 64 years	65 years and over
Total.....	6,007	143	3,481	2,383	755	.....	356	399	5,252	143	3,125	1,984
Not reported.....	25	.....	17	8	5	.....	2	3	20	.....	15	5
Reported.....	5,982	143	3,464	2,375	750	.....	354	396	5,232	143	3,110	1,979
Prolonged residence because of age or chronic disability.....	3,131	10	1,178	1,963	559	.....	216	343	2,592	10	962	1,620
Temporary medical care.....	1,772	123	1,331	318	102	.....	59	43	1,670	123	1,272	275
Temporary shelter pending finding employ- ment.....	1,059	10	955	94	89	.....	79	10	970	10	876	84

fact is that New York City, because of its adequate hospital and clinic facilities, is hesitant in sending cases needing medical attention to public homes, whereas upstate counties not having the elaborate medical facilities available in New York City are more willing to send cases requiring medical attention to public homes because of the expense involved in hospital care. See Table 40.

There were 4,666 diagnoses submitted for 3,350 first admissions, indicating that in many cases multiple diagnoses were given. Thus we find that 55.8 percent of all first admissions had some form of medical disorder, some cases having as many as three ailments. The most prevalent medical disorder was found in the cardiovascular disease group. This group consisted of 1,902 diagnoses, or 56.8 percent of the total number of diagnoses submitted. Other diagnostic groups appearing next in order of frequency are neurological and psychiatric conditions, 13.9 percent; traumatic conditions, poisonings, 12.3 percent; rheumatic diseases, disorders of metabolism and endocrine glands, vitamin deficiencies, 8.1 percent; etc. An observation worthy of comment is that 99 confinement cases, or 1.6 percent of the total number of first admissions, were admitted to public homes for delivery during the year of 1938. See Table 41.

TABLE 41

## New York State

PERSONS ADMITTED FOR THE FIRST TIME TO PUBLIC HOMES IN THE YEAR ENDING DECEMBER 31, 1938, CLASSIFIED BY DIAGNOSTIC GROUP AND BY SEX

DIAGNOSTIC GROUP	Total	Percent	Male	Percent	Female	Percent
Total.....	13,350	100.0	12,385	100.0	965	100.0
Infectious diseases.....	135	4.0	112	4.7	23	2.4
Neoplasms.....	97	2.9	59	2.5	38	3.9
Rheumatic diseases, disorders of metabolism and endocrine glands, vitamin deficiencies.....	272	8.1	170	7.1	102	10.6
Traumatic conditions, poisonings.....	413	12.3	304	12.7	109	11.3
Puerperal state.....	99	3.0	.....	.....	99	10.3
Neurological and psychiatric conditions.....	467	13.9	318	13.3	149	15.4
Diseases of the eye and ear.....	255	7.6	169	7.1	86	8.9
Cardio-vascular diseases.....	1,902	56.8	1,403	58.8	499	51.7
Blood, splenic, lymphatic diseases.....	37	1.1	19	0.8	18	1.9
Diseases of the respiratory system.....	199	5.9	175	7.3	24	2.5
Diseases of the digestive system.....	137	4.1	111	4.7	26	2.7
Peritoneal and other abdominal conditions, hernias....	269	8.0	256	10.7	13	1.3
Diseases of the uro-genital system.....	94	2.8	58	2.4	36	3.7
Diseases of the skin, cellular tissue.....	175	5.2	118	4.9	57	5.9
Non-traumatic diseases of bones and organs of movement.....	115	8.7	95	4.0	20	2.1

<sup>1</sup> This total does not equal the sum of the individual groups since multiple diagnoses were reported for some persons.





## Chapter II

### MEDICAL CARE PROGRAMS OPERATED BY DEPARTMENTS OF PUBLIC WELFARE

New York State (Exclusive of New York City)

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The increasing demand for medical care for those unable to provide it for themselves requires careful consideration of the existing public programs for distribution of medical care. Provision of medical care for the needy has been traditionally an expression of neighborly helpfulness. As a larger proportion of people in the community have become unable to provide care for themselves, organized medical charities, both public and private, have supplemented the assistance given by the individual.

In New York State, public responsibility for medical care of the needy is carried partly by local welfare departments as an integral part of the relief program, partly by health departments and partly by hospitals maintained at public expense. In New York City, the major part of the medical care program is carried by the Hospital Department which operates an extensive system of city hospitals and clinics, with the Welfare Department responsible for medical care in the home for persons to whom it is granting relief. In the territory outside of New York City, responsibility usually rests on the local welfare departments though in a few cities, the health department provides physician's services in the home and in some clinics.

In order to understand the organization of the welfare medical care programs, it is necessary to review the local relief administrative structure. Under State statutes, relief is now administered and financed by three units of local government—the town, the city and the county. The State has power of supervision over all forms of relief administered by local agencies and reimburses the localities for part of the cost of several forms of relief. The Federal Government provides, through the use of Social Security funds, a part of the cost of old age assistance, aid to dependent children and aid to the blind.

While there has been no decrease in the legal responsibility of the localities for the administration of relief through various local agencies, the system of State aid for relief has given the State definite responsibilities for determining the quality and methods of local administration, particularly of those types of relief to which the State contributes.

The Public Welfare Law of 1929 under which the State now operates, changed the whole concept of public relief and care. Whereas the Poor Law had emphasized almshouse care as the basic

form of relief, the Public Welfare Law made home relief the fundamental method, with other types of care authorized when needed. It also established public responsibility for provision of medical care for "persons otherwise able to maintain themselves who are unable to secure necessary medical care", i.e. the so-called "medically indigent."

For the purpose of local administration of public relief, the State is divided into 57 county public welfare districts and six city public welfare districts which have the same powers as a county district. The administrative head of each public welfare district is known as the commissioner of public welfare. Forty-six cities which form part of a county public welfare district, appoint city public welfare officials, and in each of the 811 towns which administer relief, the town board appoints a public welfare officer or authorizes the supervisor of the town to act in this capacity. In 49 of the 57 county public welfare districts, responsibility for the administration and cost of relief is divided between the county public welfare district as a whole, and the towns and the city or cities located in the district. In the other eight county districts town responsibilities have been transferred to the county.

To provide for the varied requirements of the needy, many types of relief are authorized such as home relief, veterans' relief, old age assistance, aid to dependent children, assistance to the blind, care of children in institutions and boarding homes, hospital care and institutional care for adults in public homes or private institutions.

Medical care is an essential part of each of these types of relief. The Public Welfare Law states that "The public welfare district shall be responsible for providing necessary medical care for all persons under its care and for such persons otherwise able to maintain themselves, who are unable to secure necessary medical care. Such care may be given in dispensaries, hospitals, the person's home or other suitable place." Hospital care may be provided in a public hospital or a private hospital inspected and certified by the State Board of Social Welfare. Medical care in the home is included in the definition of home relief, for which State aid of 40 per cent is payable. State reimbursement is payable only for medical care granted subject to the regulations specified in the Medical Manual of the State Department of Social Welfare. Hospital care is a local expense, except for State reimbursement of 100 per cent for hospital care provided for "state charges" and, of 75 per cent for a limited amount of hospital care for those receiving old age assistance and aid to the blind.

Medical relief to the indigent and medically indigent is administered by the 108 local departments of public welfare, of which 57 are county departments and 51 are city departments. In 811 towns, the town welfare officers administer, subject to supervision by the county commissioners, medical care in the home or at a physician's office for persons residing and having a settlement in

their towns. All city departments provide medical care in the home and hospitalization for their home relief recipients and medically indigent persons and in six city public welfare districts also for old age assistance recipients. A few cities are responsible for all forms of relief and therefore for medical and hospital care for all persons residing in their territory. The county department administers all forms of relief, which are not provided by the cities and towns in its public welfare district, including hospital care for town residents.

As medical care is provided for recipients of each form of relief and responsibility for administration of the various forms of relief is divided between three units of government, the system for administration of medical care is very complex. In some cities, for example, medical relief is provided by the city department of public welfare, by the county department of public welfare and by the county board of child welfare, depending upon the form of relief which the needy person is receiving or upon his settlement status. With such a complicated administrative system, it is inevitable that there should be great variations in policies and procedures. Medical care is usually easily available to persons receiving other forms of relief. The greatest variation appears in the granting of medical care for the medically indigent. Some departments have adopted relatively liberal policies in respect to the granting of medical care, and particularly hospital care to needy persons who are not receiving relief. In other localities the economic standards applied to determine eligibility for medical care at public expense are so low that persons above the destitution level are able to secure medical care only in cases of prolonged and expensive illness. Generally speaking the welfare departments receive relatively few requests for physicians' services from persons not on relief. The present public welfare medical program, insofar as medically indigent cases are concerned, operates far more effectively for provision of hospital care than for provision of medical services which might prevent serious illness requiring hospitalization.

In administering public medical care, the welfare official who is not himself trained in medicine, must make use of the medical resources which he finds in his community. He uses the services of physicians, dentists, nurses, pharmacists and related personnel, hospitals, nursing homes, clinics and laboratories. He must provide for the distribution of drugs, medical supplies and prosthetic appliances. A variety of methods are used by welfare departments to secure and pay for medical services. To provide the services of a physician, one or more of the following methods are commonly used:

1. Employment of physicians on a fee-for-service basis, either giving the patient free choice of physician or limiting the choice to a selected panel of physicians.
2. Use of public or private clinics,



3. Employment of staff physicians to treat patients in their offices and in the patient's home with specialists on a fee-for-service basis.

4. Employment by the public welfare department of staff physicians to treat patients in the patient's home, or a clinic maintained by the welfare department.

5. Use of salaried physicians employed by a city department of health for services in the home or in clinics, with or without supplementation of this service by employment of general physicians and specialists on a fee-for-service basis when needed.

6. By any combination of the above methods.

It is not unusual for a welfare department to use different methods to provide medical service for recipients of relief in the different categories. For example, recipients of home relief may be treated by staff physicians, while recipients of old age assistance and obstetrical or other special cases may be given service on a fee basis. It is customary to provide medical care for inmates of county homes by salaried physicians, though the county departments seldom provide medical care by salaried physicians for any other type of relief.

The method of providing hospital care depends upon the facilities in each community. A few localities maintain a public hospital which provides care for welfare patients. In the absence of a public hospital, welfare departments provide care in voluntary hospitals through a per diem payment. Welfare departments usually have agreements with hospitals as to the per diem rate to be paid and the extent to which extras such as fees for the use of operating room, anesthesia, drugs, x-rays, laboratory service, etc. will be paid. In hospitals having no staff or in proprietary hospitals the welfare department sometimes pays fees to physicians and surgeons attending public welfare patients.

It has been estimated that the cost of medical care given by the local welfare departments (exclusive of New York City) on which the State reimbursement was paid for the year ending June 30, 1939, amounted to approximately \$3,000,000. The category of home relief accounted for \$1,644,403 of this amount. Old age assistance recipients accounted for \$496,385 for hospital care and \$824,039 for home care. Other relief categories accounted for the balance. Public expenditures for general hospital care outside of New York City for the calendar year 1939 amounted to \$10,336,000.

The expenditures for home medical care have markedly increased during the past decade. Outside of New York City in June 1932 the expenditures for medical care in the home were \$25,000 which in 1939 rose to approximately \$200,000 as the average monthly expenditure.

There is a great variation in the administrative methods and procedures for distribution of medical care to the needy in the public welfare departments. Local plans have been markedly expanded and new ones are steadily being instituted. In the larger unit

there is a trend toward the employment of a physician in the capacity of director or consultant in order to secure better administrative control and through professional supervision, improve the quality of medical care. In the majority of the departments, however, there is a distinct lack of centralization and responsible administrative direction in the medical program.

The Commission has reviewed current surveys of local medical care programs of welfare departments made by the professional staff of the State Department of Social Welfare, following the inventory outline shown in Appendix E, on page 451. While no two programs among those of the 108 districts are entirely identical, the following examples will serve to illustrate some of the variations in policies and procedures:

### **Chautauqua County**

Chautauqua County represents a common type of welfare district medical care program. The medical care program of the County Welfare Department excludes the two cities within the boundaries of the county, each of which administers its own medical care program.

Medical care for old age assistance and assistance to the blind is administered from the County Commissioner's office by a Deputy Commissioner. Because of the centralized control for these categories of public assistance, a closely knit medical program is possible, but definite policies and procedures have not been established. The individual investigators usually plan medical care for their clients and authorize medical care without supervision. The county department also provides medical care for children in boarding homes. The county board of child welfare carries responsibility for some medical care for recipients of aid to dependent children.

Medical care for home relief clients is administered by the 27 town welfare officers nominally under the supervision of the home relief case supervisor in the County Commissioner's office. The county department does not attempt to bring about uniformity in the medical care program of the towns. In one town medical care is provided by a salaried physician, in all other towns it is provided by private physicians on a fee-for-service basis. One town, recognizing the value of medical supervision, requests the Town Health Officer to review and approve all recommendations for hospitalization made by the physicians. In six towns so little medical care is provided by the welfare officers that they have not thought it worth while to request reimbursement from the State Department of Social Welfare.

It is stated that very little investigation is made of requests for medical care, and so far as is known requests are never refused. There is a paucity of records regarding both the health condition of clients and the medical care provided. Often no welfare authorization is given for medical care at the time the care is given,

but retroactive authorization is given after the professional attendant submits a bill for the services. There is no control of drug expenditures. The usual practice has been to authorize drugs after the druggist have submitted bills for them.

The situation in this county reflects its mainly rural character. It is reported that a spirit of neighborliness and helpfulness in the community is in part responsible for the fact that the welfare officers do not need to provide as complete a program (including medical care) as is necessary in more densely populated districts. Neighbors are accustomed to help in homes where illness occurs. When relief families need a physician's care, the family physician frequently provides medical attention without requesting payment.

### **Allegany County**

A Department of Public Welfare operated as a county unit makes for simplification and unification of both administration and services. Full use is made of many of these advantages in Allegany County where the Welfare Department operates as a county unit administering all categories of public assistance.

In this county when a relief recipient needs medical care he calls his family physician. The physician examines the patient, provides whatever treatment may be necessary and usually dispenses whatever medicine is needed. If a prescription is needed, for either drugs or medical supplies, the physician writes it on the spot and gives it to the patient or a member of his family to take to the nearest pharmacy where it is filled without delay. If the patient needs to go to a hospital or requires laboratory or specialists' services, the physician takes the necessary specimens and makes the arrangements with the laboratory or the hospital for examination or treatment. If a home medical aide is required the physician's wishes are respected.

The patient is not required to apply directly to the Department of Public Welfare in the first instance for any of the above professional services or supplies. If the physicians or the hospitals wish to be paid from public funds they telephone or write to the nearest district investigator representing the County Department of Public Welfare. This investigator who carries, as a rule, a case load consisting of all relief categories in his district, can give the physician or the hospital a prompt decision as to the eligibility of the patient for treatment at public expense. All the arrangements for a patient, regardless of the category of the public assistance for which he or she may or may not be eligible, are the initial responsibility of a single investigator on the staff of the county department. Hence, social problems existing in the family can be met by the investigator with a full awareness of the current medical needs existing in that family.

The general policy of the department is never to refuse a physician's request for authorization of care if the patient is an active recipient of any category of public assistance. On the other hand, the physician's request for authorization to care for a patient not



receiving public assistance is less frequently granted, particularly if the request is for home or office care and does not involve hospitalization. However, the department has a blanket category of "outdoor relief" which is used by the investigators as a device for authorizing either hospital care, or other forms of medical care on a non-reimbursable basis, without a complete investigation or a formal opening of the case for public assistance.

Unified control, or at least clearance for all professional services and supplies, is provided by the requirement that the initial commitment by the investigator for care or supplies for an eligible patient be promptly forwarded to the county office for a review and final decision by the case supervisor.

The county medical society has an advisory committee which meets periodically with the Commissioner of Public Welfare. As a result agreement has been reached regarding a schedule of fees for physicians' services, including surgery, to patients treated in their homes, in the physicians' offices and in the hospitals. There appears to be a good working agreement with the three hospitals within the county and two more hospitals in a neighboring city.

### **City of New Rochelle**

The New Rochelle Department of Public Welfare has a medical unit which operates a diagnostic and therapeutic clinic as well as a pharmacy in the city welfare office for the distribution of drugs more economically purchased in bulk. This unit provides both home and ambulatory care. A salaried physician serves as director of the medical care program and is responsible for supervision of the clinic and of the authorization of hospital care. The medical staff of the clinic consists of four to five part-time salaried physicians selected on a rotating basis from a panel of local physicians in private practice. They serve for a period of three successive months. A psychiatrist, gynecologist and cardiologist also serve in the clinic on a part-time basis. When needed, other specialists' services are secured on a fee basis or by referral to a clinic. The medical unit also arranges for visiting nurse service in the home.

The local voluntary hospital is utilized for specialists' services, including physiotherapy, in the out-patient department and for x-ray and laboratory facilities. Advantage is also taken of other organized medical facilities offered by the State, county and city. Hospital care is provided in the local voluntary hospital and in Grasslands Hospital operated by the County Department of Public Welfare.

Through social service investigation the use of the Welfare Department's medical services is restricted to those receiving other forms of relief and persons whose resources do not permit them to secure medical care. The integration of the medical and social history of each individual leads to intelligent and effective case work and also allows for ready evaluation of the entire program from the viewpoint of community service and economy.

### City of Rochester

In the city of Rochester for many years the Department of Health has been responsible for giving medical care in the home. The responsibility for the medical program for which the city pays is thus divided between the Health and the Welfare Departments. Persons living in Rochester who receive the form of relief administered by the county receive medical care from still other agencies. The complexity of the situation can be seen by the following outline of the number of administrative agencies through which persons living in Rochester receive medical care at public expense:

1. The Medical Service Division of the City Welfare Department, under the direction of a part-time physician. This division authorizes acceptance of patients as public charges in hospitals, reimburses the voluntary hospital clinics for services rendered to home relief recipients and authorizes expenditures for drugs, medical appliances, etc.

2. The City Health Bureau, under the direction of the city health officer. Twenty part-time salaried physicians are employed to give medical care in the home to recipients of home relief, and certain other needy sick. The Health Bureau provides home nursing services and cooperates in referral to diagnostic and therapeutic clinics for all groups of the medically needy. The Rochester City Municipal Hospital is operated under the fiscal supervision of the Health Bureau.

3. Child Placement Medical Service of the County Department of Welfare. This division of the county department operates a clinic under the direction of a part-time pediatrician, paid from private funds. Two other part-time salaried physicians provide home and clinic care and specialists' services are provided through the out-patient departments of voluntary hospitals. One part-time dentist is employed and additional physician services are paid on a fee basis when needed.

4. Old Age Assistance and Aid to the Blind Division of the County Department of Public Welfare. General physicians and specialists paid on a fee-for-service free-choice basis provides medical care in the home or office for old age assistance and blind assistance cases living in Rochester. The voluntary hospital clinics, however, provide care free of charge for these county cases, though the City of Rochester pays for clinic service provided for home relief cases.

5. Home relief non-settled and State-charge cases residing in the city are cared for by five salaried part-time physicians paid by the County Department of Public Welfare.

6. County Board of Child Welfare. Home medical care for recipients of aid to dependent children residing in Rochester is provided by the salaried physicians employed by the City Health Department; ambulatory care is provided free of charge through

the out-patient departments of the voluntary hospitals; and, hospital care is provided either through the municipal hospital under the City Health Department or upon certification of the City Welfare Department in voluntary hospitals. Part-time salaried pediatricians of the Health Bureau also give medical service in the home and at health clinics for this group.

7. A municipal ambulance service is operated by the Department of Safety and grants for ambulance service are made also to voluntary hospitals by the Department of Welfare.

8. Visiting nursing service on a fee-per-visit basis is paid for only for recipients of old age assistance—recipients of aid to dependent children, assistance to the blind and non-settled home relief cases get this service free of charge.

The complex situation in Rochester shows dispersion of administrative responsibility for the provision of public medical care for the residents of Rochester which results from the division of responsibility for administration of public assistance between the city of Rochester and two county agencies—the County Department of Public Welfare and the County Board of Child Welfare, and the division of responsibility between the Health Department and the Welfare Department in Rochester.

### Summary

The following summary of findings is based on a review of public medical care programs administered by local welfare departments.

Although in all of the welfare districts under study there existed organized administrative programs for the distribution of medical care to public relief recipients, in many instances the lack of understanding of the relationship between medical and social problems prevented effective use of all the existing facilities.

In some of the districts studied the social service and the medical care programs functioned independently of one another. In many instances personnel of the local social service division were unfamiliar with the medical problems of their clients and the local medical care facilities. The social case records rarely included data on health problems or medical services. Social planning was deficient in respect to medical social case work designed to effect social and medical rehabilitation.

The programs studied showed a lack of centralization or responsible administrative direction. In most instances the local distribution of medical care to the several relief categories had separate and uncoordinated administrative mechanisms. Many methods of authorizing medical care were in force. In some instances the authorization was practically automatic where as in others the use of medical facilities was frequently discouraged in order to reduce tax expenditures. When a lay welfare officer did attempt to differentiate between applicants on the basis of medical need he either acted on the basis of his inadequate grasp of medical problems or he found it necessary to seek the advice of a physician.



Study of medical care plans in operation gave clear evidence of the need for medical direction and supervision. For the sake of efficiency and economy professional medical judgment should be brought to bear on the problems of providing appropriate preventive and curative medical care for the needy.

It was found that welfare officers were usually aware of the total costs of their medical care programs but did not have readily available data on costs for various items, individual clients or types of illness. Such data are essential in future planning and administration of public medical care programs.

Another weakness of the present program is the lack of coordination of the various medical and public health programs, public and private. While the welfare departments necessarily have developed working relationships with the voluntary hospitals, it was frequently found that there was little relationship between the welfare department and the health department. Further integration of the welfare medical program and the public health program is essential to secure maximum results from present public expenditures in these fields.

Under the present public medical care program, medical care is as a rule available to persons receiving relief. The scope of the Commission's study does not permit any evaluation as to the adequacy of this medical care from the point of quality. The situation in regard to medical care for the medically indigent group not on relief is far from satisfactory. A considerable amount of hospital care is provided though the extent to which the public welfare authorities have accepted responsibility for payment of hospital care for this group varies greatly. Relatively little home medical care is provided for this group by the welfare departments.

In contrast to this, in New York City, the requirement of the Public Welfare Law in relation to the provision of all types of medical care for the non-relief case is ignored. The New York City Department of Public Welfare provides medical care in the patient's home only for persons to whom it grants relief, and there is no public provision whatsoever for this type of care for persons not on relief. The medically indigent group in New York City have available extensive public and private clinic services, but if they are unable to pay for the services of a physician in their home they must depend upon the charity of a private physician or call an ambulance from one of the hospitals.

While the welfare departments in the rest of the State recognize their responsibility under the Public Welfare Law for provision of home medical care as well as hospital care for persons not receiving relief, the fact remains that relatively little home medical care service is provided for this group by the welfare departments. The Commission's study of medical care received by ward patients prior to admission to the hospital indicates that the medical needs of this group are not being well met and that serious consideration should be given in order to make more readily available home medical care for the medically indigent not on relief.

Further study is obviously needed of the policies and practices of the welfare departments in administration of the medical program for persons not on relief. The great variation in the economic standards used to determine eligibility, both for home medical care and hospital care, must be corrected and ambulatory care must be made more readily available, if the present public medical care program is to operate effectively in meeting the medical needs of this large group of the population.

### Recommendations

Leaders in both the health and welfare fields have recognized the need for integration of health and welfare efforts. The following clear statement by Paul V. McNutt, Federal Security Administrator, expresses this viewpoint:

"In planning for health security, we must build on which we have, utilizing all existing facilities capable of rendering effective medical and health service. Sound planning and good administration are basic to any aspect of the welfare program. Without these, effective service is impossible. Along the road ahead where public-welfare agencies and public-health departments must meet in a coordinated approach to the expansion of public services in a community, it is especially necessary that no superfluous administrative machinery be set up."

The following policies and procedures are recommended by the Commission as basic to efficient operation of public medical care programs by local welfare departments:

1. Greater centralization and integration of the administration of medical care to all categories of relief.

2. Professional medical direction of the medical program in order that medical judgment may be brought to bear on the problems of providing appropriate preventive and curative care for relief recipients and the medically needy and of keeping expenditures at the lowest cost consistent with quality and efficiency.

3. Effective working agreements between the welfare departments, medical care and public health agencies in the community in order to effect a full utilization of existing facilities and elimination of expensive duplication.

4. Better coordination of medical care and social service functions in the welfare departments, to insure the complete individualization of each patient's medical rehabilitation within the limitations of his disease or infirmity.

5. Accurate recording of data concerning not only the total cost of the medical care program but also the costs for various items, individual clients and types of illness.

6. Adoption of policies which would make more fully effective the provisions of the Public Welfare Law in relation to the provision of medical and hospital care to those otherwise able to maintain themselves who are unable to secure necessary medical care.

If medical care of good quality is to be made available at public expense for persons not able to provide such care for themselves, the advice of a duly licensed physician is essential in the determination as to the medical care necessary. This fact became so obvious during the course of the deliberations of the Commission with other interested agencies that a bill was introduced in the legislature at the request of the Commission, to incorporate this concept into Sections 83 and 85 of the Public Welfare Law. This bill, with the signature of the governor, became Chapter 682 of the Laws of 1940, effective April 21, 1940. For full text of this act see Appendix F, on page 455.



## Chapter III

### PATIENTS DISCHARGED FROM HOSPITAL WARDS, 1939

This study is based on an analysis of the hospital and welfare records of 2,099 patients discharged from the wards of 11 representative hospitals in New York State, exclusive of New York City, during 1939, together with an analysis of the interviews obtained through personal visits to 771 of these patients.

#### Introduction

The Commission in its preliminary report to the Legislature submitted May 15, 1939, included the following among its recommendations for further study:

“Study of the need for diagnostic laboratory, and consultant and specialist services, as well as a modern clinical, diagnostic and therapeutic armamentarium available to all physicians, through public facility, if necessary. In meeting this need, consideration should be given to the full utilization of existing approved general hospitals.”<sup>1</sup>

A study along these lines should take into account, not only the quantity of medical care, but also its quality. This study was planned to obtain an insight into problems of medical care in communities of various types served by a variety of general hospitals. It was hoped that the data from such a study would aid in planning a long range health program.

It was decided to select for study a group of persons known to have been seriously ill. Histories of serious illness should shed light on the factors involved in securing medical aid. Both medical and economic data were studied to determine the type and effectiveness of the medical care provided. Correlations between data of these two types for a significant number of cases was expected to throw new light on problems involved in the adequate distribution of medical services.

To study the course and effect of severe illnesses, records of individuals with a recent illness experience in a hospital were used. Specific diagnoses are usually recorded for persons who have been hospitalized. By going to the records of patients already discharged from the hospitals the progress of disease at a certain point has been evaluated by persons competent to make medical judgments. Material dealing with catastrophic experience in the medical and economic history of the individual can best be found in a hospital, since ordinarily only the severe case of illness reaches the hospital.

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<sup>1</sup> Preliminary Report of the New York State Temporary Legislative Commission to Formulate a Long Range State Health Program, Legislative Document (1939) No. 97, page 7.

This is true not only from the point of view of the patient and his family but also from that of the physician and public agencies.

There is a group of persons in every community who cannot bear the extra burden of severe illness. These people are otherwise able to maintain themselves but cannot pay for necessary medical care. Persons already receiving other forms of relief are of course even more dependent on public funds when illness strikes. It was decided to study patients discharged from hospital wards, since these two groups make up a large proportion of the admissions. For ward patients the continuity of disease history, the medical care provided and the ways of meeting the hospital and medical bills are matters of record. The fact that an individual has had a hospital experience provides a focus in his medical history from which it is possible to trace factors relating to the availability and adequacy of the medical service he gets together with the economic problems involved.

To obtain a fair sample studies were made of records of ward patients in different types of hospitals serving rural, suburban and urban communities.

Hospital staff organization and the accessibility of hospital facilities, including diagnostic and curative services, is reflected in the activities of each medical practitioner in the hospital area, and may greatly influence the type of medical care which each individual patient receives.

Another consideration in the choice of communities for study was the degree of community organization to meet health and welfare needs. Some of the communities in which the hospitals studied were located had full-time health officers and health departments, while others were served only by local part-time health officers. Some of the areas were served by adequately organized clinics while others had a few special clinics. One area was served by a centralized county welfare department while most of the remaining counties had county and town welfare officials working independently.

A brief descriptive summary of the communities chosen for study and an inventory of some of the health facilities is presented in Table 42.

The 11 general hospitals studied varied both with respect to the type of control, public or private, and, in the communities they serve, the extent to which they met the standard ratio of general hospital beds per thousand of population. According to the American Public Health Association, this standard is 4.5 general hospital beds per thousand of population.

A hospital, in order to fulfill its purpose, must be readily accessible to the population it serves both in respect to geographic location and ease of gaining admission (even when limitations of economic resources would seem to present a barrier). The hospitals studied vary in respect to these factors also. A brief descriptive summary of the hospitals studied is presented in Table 43.

## Method

Ward cases at each hospital were selected when possible in reverse order of discharge, the series beginning with the most recently discharged patient. Responsibility for payment of hospital charges was not known at the time case records were copied. The presence of incomplete history records at times made a break in sequence unavoidable. Emergency, accident and psychiatric cases were excluded. Accident cases were excluded because they present such a short medical history prior to hospitalization and psychiatric cases because the history in such cases were found to be vague and hence of questionable reliability. Police call cases were rejected from the series in copying records from city Hospital C.

The part of the field work devoted to transcribing record source material extended from October 1, 1939, through February 2, 1940. Since the series of cases began with the ward patient most recently discharged from each hospital at the time that it was reached by the field worker, and since the rate of patient discharge varied from hospital to hospital, the earliest discharges from the various hospitals fell on different dates. However, in the series studied, no discharge occurred prior to February 1939. This method of selecting cases failed to provide an even distribution of cases throughout the year. The size of the sample selected from each hospital was decided on the basis of the population of the area served and the total annual admissions to the hospital. The samples ranged in size from 80 to 600 ward patients.

The primary emphasis in the study of medical records was on the history of each patient's disease in terms not only of medical sequence but also of individual and family welfare. No attempt was made to evaluate the quality of hospital care. The illness which led to hospitalization was considered the major subject of study. This study required information relating not only to the type of illness of each patient but also to its duration and severity, the stage of disease when medical care was first given and the results of the diagnostic and curative measures provided. Among factors considered were the types of medical care provided, who gave the care, and the method of payment for the care given. Statements concerning physical examinations, and especially the use of laboratory procedures, were used as evidence of the extent to which modern diagnostic methods were used.

Inquiry was made concerning use of home remedies. Evidence was sought of the extent to which the use of preventive measures would have mitigated the disease process and lightened the economic burden. When delay occurred in securing prompt medical attention, an attempt was made to determine whether the reason was deficiency in medical facilities, inability to pay for medical care, lack of appreciation of the need for medical care, or sheer neglect.

In order to obtain a fair basis for interpreting data relating to medical care, inquiry was made into the economic background of the



family. Relief history was considered part of the essential data, since serious illness may be a cause of indigency or vice versa.

As evidence of prevailing habitual behavior in relation to medical problems, it was thought desirable to seek information concerning the use of a regular family physician and the extent to which there were periodic physical examinations and physical examinations before the onset of illness.

### Specific Procedure

The data desired were collected in two stages. First the hospital and, where existing, welfare records for each patient were reviewed and the required information copied. For this purpose a schedule (Form I) was designed (See Appendix G, page 456). A provisional analysis of 2,099 cases for which the form was completed is presented in this report.

Next, public health nurses were sent into the field to question these patients concerning their medical experience and economic background. For this purpose a second schedule (Form 2) was employed (See Appendix H, page 457). A provisional analysis of 771 of these completed schedules is included in this report.

In October 1939, explanatory letters were sent to the 11 hospitals selected for this study requesting their assistance and cooperation in securing the data from the patient history records and the hospital credit offices.

The Chairman of the Commission made personal visits to eight of these hospitals in order to establish liaison for the Commission field representative. In addition, the Medical Research Director conferred with members of the medical boards of eight hospitals. In nine instances, at the express request of the hospitals, subpoenas for records were obtained. Excellent cooperation and assistance in the study was obtained from all of the hospitals and their medical boards.

A graduate nurse with training and experience in hospital and welfare administration was employed to secure data from hospital and welfare department records. After copying the data from the patients' history and hospital credit records, this field worker visited the local public welfare offices in order to determine, which of the hospital ward cases were already authorized at public expense and, which cases were still pending.

The 2,099 completed Form 1 schedules were statistically analyzed in the home office of the Commission staff by a statistician, aided by personnel made available by the State Departments of Health and Welfare. The punch card machinery of the State Health Department was placed at the disposal of the Commission. The statistical codes developed for these data together with a discussion of the editing policy may be found in Appendix I, page 462. Specific discharge diagnoses were coded by a physician.

### Analysis of Form 1 Data (From Hospital and Welfare Department Records)

All of the data were obtained by one field investigator and the entire group of records was analyzed by a uniform method.

Form 1 was designed to be used in transcribing data from written records in hospitals and welfare departments. In addition to the name, address, age, sex and occupation of the patient, the form called for admission and discharge dates and diagnosis, condition on discharge, whether referring physician or staff physician treated patient in hospital, whether social service and hospital credit office investigations were conducted, agency responsible for payment of hospital charges (and method of payment if patient was responsible) and to what agency the patient was referred for follow-up.<sup>2</sup>

The information tabulated in this study from Form 1 consisted of the following data: hospital, age, sex, color, civil status, occupational group, length of stay in hospital, discharge diagnosis, whether surgery was performed, survival, physician who treated patient in hospital, agency responsible for hospital payment (including method of payment when patient was responsible). Additional information which was coded was found to be unsatisfactory and will not be presented until it can be verified by correlation with information obtained by means of personal interview with the patient, or from other sources.

The information was coded and transferred to punch cards for mechanical sorting. Tables 45 through 62 show the resulting summaries.

### Provisional Findings from Form 1 Data

*Age Distribution by Hospital* (See Table 45-A).—Cases were grouped by age as follows: under 1 year; 1 year and under 2 years; 2 years and under 5 years; 5 year intervals thereafter through 25 years; 10 year intervals from 25 years to 65 years; and a final category for 65 years and over.

When the combined data for all hospitals were arranged according to age categories, the distribution showed no unexpected features. The maximum frequency was reached in the age group 25 to 35, which accounted for 17.4 per cent of all cases. One hundred sixty-five of the 365 patients in this age group came to the hospital for puerperal conditions. Beyond age 35 the numbers hospitalized in each successive decade fell off until reaching the group aged 65 years and over. Although the individuals over 65 years of age are numerically fewer in the community, they contributed disproportionately to this hospital population. Due to the frequency of tonsilectomy, communicable diseases of childhood and middle-ear infections, the 5 to 10 year old group contributed more individuals to the hospital population than did the group

<sup>2</sup> See Appendix G, page 456, for reproduction of Form 1.

10 to 15 years of age. See Charts 2 and 3, on pages 25 and 26 for other age distributions.

The small size of the samples in each group prevented direct comparison from hospital to hospital, since the shift of a few cases would have completely changed the picture. However, there appeared to be a disproportionate number of infants under 1 year of age in Hospital J, compared with the average for all hospitals studied. Review of the specific diagnosis failed to reveal any predominant cause for this. A few hospitals, notably B, H, I and J<sub>2</sub>, show disproportionately large numbers of children in one or more of the age groups under 15 years of age. It may be significant that all of these hospitals serve rural areas. At Hospital B, the existence of an epidemic of poliomyelitis during the period covered by our study may have been partly responsible for the large number of children. At Hospitals H, I and J<sub>2</sub>, the high proportion of tonsillectomies performed accounted for the large number of children treated. In Hospital H, for instance, of the 23 patients in the 5 to 10 year age group, 21 came to the hospital for tonsil operations.

At Hospital A there were more patients in the age groups 15 to 20 and 25 to 35 than was usual in this series, whereas there was a disproportionately low number in the older age groups. Of the 17 cases at this hospital aged 15 to 20 years, 10 were diagnosed as appendicitis, and 3 were obstetrical cases. Of the 25 patients in the group 25 to 35 years of age, 7 were diagnosed as appendicitis and 7 were obstetrical cases.

At Hospital I the number in the age group 20 to 25 years was disproportionately high. A review showed that 22 of the 32 patients in this group were obstetrical.

At City Hospital C, there were proportionately more patients more than 35 years of age than at other hospitals studied. A review of the diagnoses of the patients in the older age groups in this hospital revealed no unexpected features.

*Sex by Hospital* (See Table 45-B).—For the entire group of patients there was noted an excess of females over males in the ratio of about three to two. All the hospitals had more female than male patients, except city Hospital C in a metropolitan area. At the rural hospitals studied a higher proportion of female patients obtained, undoubtedly due to the fact that a large portion of the ward care at these hospitals was obstetrical. In rural Hospital G the highest proportion was reached. There 72 per cent of the total were female patients.

*Civil Status by Hospital* (See Table 45-C).—Civil status was stated explicitly or could be derived in all but 141 cases. The distribution obtained is presented in Table 45.

*Occupational Group by Hospital* (See Table 45-D).—An attempt to classify the patients in the study according to their occupational group resulted in the tabulation presented in Table 45-D. The



housewife group accounted for 722 cases, or nearly 60 per cent, of the entire group of female patients studied. This constituted the numerically largest occupational group in the study.

*Length of Stay in Hospital by Hospital* (See Tables 46, 47, 48, 49 and 52).—Table 49 shows that the mean (average) length of hospital stay was 15.92 days and the median (middle) length of stay was 10.59 days for the 2,093 cases included in the study for whom length of stay in the hospital was reported. An attempt was made to determine the effect on length of stay in hospital of factors such as surgical procedures type of illness, and the agency or individual responsible for the payment of the hospital charges. Chart 10 on page 47 shows hospital ward patients classified by surgery and by length of stay in hospital.

Actual length of stay by hospital is shown in Table 46 and is analyzed in terms of mean and median number of days stay in Table 48. It may be seen that patients stayed longest in hospitals serving metropolitan areas. At Hospital C the mean stay was  $7\frac{1}{2}$  days longer and the median 4 days longer than for all hospitals combined. In Hospital D the mean stay was  $3\frac{1}{2}$  days longer but the median stay was only 1 day longer than for all hospitals studied, indicating that the longer mean stay in this hospital had been due mainly to a relatively small number of patients who stayed an unusually long time. At hospital J<sub>2</sub> the mean (8.83 days) and the median (5.53 days) were the lowest recorded among the hospitals studied. These low figures are undoubtedly due to the fact that one-third of the ward patients in this hospital had been admitted for tonsillectomy.

Study of Table 49 indicates that surgical cases left the hospital sooner than non-surgical cases. The non-surgical patients stayed on the average  $4\frac{1}{2}$  days longer than the surgical patients. That this was due mainly to a relatively small number of very lengthy non-surgical cases is shown by the fact that the median length of stay of non-surgical cases was only  $1\frac{1}{3}$  days longer than that of surgical cases. A similar analysis of experience in the individual hospitals is contained in Table 48.

In order to indicate the influence that ability to pay for hospitalization may have had on the length of hospital stay, the periods of hospitalization were analyzed separately by patient and public welfare responsibility. Table 52 presents this analysis for all hospitals and for each individual hospital. The mean length of stay of patients, for whom a public welfare agency assumed responsibility for the hospital bill, was 20.42 days in contrast to 9.46 days when the responsibility fell upon the family of the patient. This is further borne out by contrast of the median lengths of stay which was 12.62 days when a public welfare agency was responsible and only 8.21 days when the patient's family was responsible. Table 61 shows in detail for each specific diagnosis the length of stay in hospital together with responsibility for payment of hospital charges.

*Discharge Diagnosis* (See Tables 53, 54, 55, 60 and 61 and Chart 11).—The discharge diagnosis copied from the hospital records were coded by a physician. A short classified list of specific diagnoses containing about 90 titles was prepared, based on the list published for Hospital Morbidity Reporting by the Welfare Council of New York City.<sup>3</sup> This list is in turn based on the "Standard Classified Nomenclature of Disease."<sup>4</sup> The main groups are in general based on anatomical considerations with the exception that general infections, neoplasms, and rheumatic, metabolic and traumatic conditions are given precedence. The list used for coding with the corresponding Welfare Council list numbers is reproduced in Appendix I.

The diagnoses of the greatest number of patients referred to the puerperal state and accounted for 390 of the 2,099 cases. Diseases of the digestive system accounted for 353 of the cases; of these 188 were diagnosed appendicitis. Diseases of the respiratory system made up a total of 339 cases of which 193 cases were infectious hypertrophy of the tonsils or adenoids. The study included 123 cases of neoplasm and 97 cardio-vascular cases. These data are shown graphically in Chart 11 based on data in Table 54. Tables 60 and 61 show discharge diagnosis in complete detail. In Table 60 data on sex, age and mortality for each specific diagnosis coded are presented. Table 61, as previously noted, presents detailed data on length of stay in hospital and responsibility for payment of hospital charges for the same list of diagnoses.

It is interesting to note in studying Table 61 that hospital bills for illnesses which were of a prolonged nature were assumed as a responsibility by public welfare officials in a higher proportion than diseases of shorter duration. Public welfare departments assumed the responsibility for hospitalization costs of 25 among the 35 cases of tuberculosis of the respiratory system. Similarly, 71 of the 123 patients with neoplastic diseases were accepted as public charges. In contrast, of the 390 puerperal conditions only 143 were accepted as public charges, and of 142 cases of acute appendicitis only 56 were accepted as public charges, for the cost of their hospitalization.

*Surgery by Hospital* (See Tables 46, 48, 49, 53 and 56).—Table 61 reveals that 40.3 per cent of all the patients included in this study underwent surgical procedures. The surgical rate differed widely from hospital to hospital. For instance, at Hospitals F and J<sub>2</sub> 60 per cent or more of all patients received surgery. On the other hand the surgical rates at Hospitals B, C and D were below 35 per cent.

<sup>3</sup> A classified List of Diagnoses for Hospital Morbidity Reporting, a preliminary report based on a study of 576,623 hospital discharges from 113 hospitals in New York City in 1933. (WPA project number 665-97-3-54.) May 1939, Research Bureau of Welfare Council of New York City.

<sup>4</sup> A standard Classified Nomenclature of Disease, H. B. Logie, The Commonwealth Fund, 1933.

The significance of tonsillectomy in the surgical group is brought out in Table 56. In this table it appears that the proportion of tonsillectomy varied widely from hospital to hospital. At Hospital B, of a total of 155 patients discharged, only 1 had undergone tonsillectomy, whereas at Hospital J<sub>2</sub>, of 105 discharged patients, 35, or one-third of the total, had undergone this procedure.

The same table segregates the obstetrical cases, exhibiting an obstetrical rate for all hospitals of 16.8 per cent. The component hospitals varied from a low of 10.7 per cent obstetrical patients in city Hospital C to 29.7 per cent in voluntary Hospital I.

*Mortality* (See Table 55).—The mortality data for the entire series is presented in Table 55. Among the 2,099 cases there occurred 168 hospital deaths. Although surgical cases made up 40 per cent of the entire group of cases, only 13.1 per cent of the deaths occurred among them. The greatest number of deaths occurred in the cardio-vascular disease group.

*Physician Who Treated Patient in Hospital* (See Table 58).—A patient may be treated in the hospital either by the physician who referred him for hospital care or by a member of the hospital staff or by both. This is to some degree dependent on local hospital policy relating to staff organization. In both hospitals serving metropolitan areas, Hospitals C and D, all patients were treated by staff physicians since physicians not on active ward service did not have access to the wards. In Hospital F, of 125 patients, 112 were treated by the doctor who referred them to the hospital. The welfare policy in this locality provided for payment to physicians for services rendered on the wards to patients accepted as eligible to receive medical care at public expense. In the area served by Hospital I similar welfare and hospital policies prevail and the figures presented bear this out. At Hospital E the referring physicians treated 132 of the total 155 cases. This city employs city physicians and surgeons.

*Responsibility for Payment of Hospital Charges* (See Tables 56, 57, 59 and 61, and Chart 12).—Eight hundred thirty-three, or 40 per cent of the 2,099 patients, were expected to pay for their own hospital care, as shown in Table 56. One thousand fifty-five, or 50 per cent, were referred to public welfare officials for hospitalization at public expense. A slightly higher proportion of surgical patients (46 per cent) than of all patients, were expected to meet the cost of their hospitalization and another 46 per cent of the surgical patients were public charges for hospitalization. A still higher proportion of the obstetrical patients (57 per cent) were expected to meet the costs of their hospitalization and only 36 per cent of the obstetrical patients relied upon public welfare.

Of the patients responsible for their own hospital charges a little less than half paid their hospital bills in cash.

A comparison of responsibility for payment of hospital charges by hospital is presented in Table 59. It is significant that for the



city-maintained Hospital C in a metropolitan area only 56 patients of a total of 599 were considered fully responsible for their own hospital charges. The policy of this hospital permitted patients to pay small amounts toward their hospitalization costs when possible; the hospital itself absorbed the balance. This group of patients who were cared for mainly from public funds have not been included with "public welfare responsibility" in any of the tables. Likewise, voluntary Hospital D, also serving a metropolitan area, expected only 56 of its 304 patients to assume full responsibility for hospital payment.

In general the hospitals of rural areas had a relatively high proportion of patients expected to assume responsibility for their hospital charges. It should be mentioned that although patients were expected to assume responsibility, the hospital might not always actually collect the full amounts due.

Six hundred nineteen of the 1,055 patients for whose hospitalization charges public welfare agencies were considered fully responsible were in the two metropolitan hospitals. In addition 152 patients at one of these hospitals were assisted by the welfare department in the payment of their hospital bills. On the other hand, in rural areas a lower proportion of cases were referred to the public welfare agencies by the hospitals.

*Source of Referral to Hospital and Follow-up Advised by Hospital for Three Hospitals Maintaining Out-Patient Departments* (See Table 62).—The data summarized in Table 62 was obtained by hand tabulation from information occurring incidentally on Form 1, although not specifically called for on the form. The tabulation involves 1,008 patients, 902 of whom survived. Information concerning source of referral to hospital was obtained for 782 of these patients. Private physicians referred 366 of these patients to the hospital. Upon discharge, 172 of these patients were noted as having been referred for follow-up not to the referring physician but to the out-patient departments of the hospitals, and 93 were recorded as having been referred back to physicians.

The summary and conclusions based on Form 1 data may be found at the end of this chapter.

### Analysis of Form 2 Data (obtained by Home Interviews)

A second schedule, Form 2, was prepared to be filled out by the nurse investigators at the time of the field interviews with patients or responsible members of their families. (See Appendix II.) Form 2, after repeating identifying information similar to that found in Form 1, calls first for a statement in the patient's words of the symptoms, date of onset and nature of the complaint or illness, which necessitated his admission to the hospital ward.

A section on "medical care" called for answers to questions concerning date of first medical attention for this illness and the place where this attention was received; date of application for admission to hospital; date of admission to hospital and date of

discharge from hospital; and also reason for delay, if any, in securing medical care.

A section on "self-medication" contained a question as to whether and for how long the patient doctored himself before securing the services of a physician for an illness which required hospitalization. If the use of a home remedy was specified, the name of the remedy used and the source of recommendation for its use were called for.

In a section devoted to facts concerning the medical care experiences of the patient prior to the illness which brought him to the hospital, he was asked whether he had a regular family physician and whether he had ever had a complete physical examination and, if so, of what this examination consisted, whether it was made in connection with life insurance, whether by a private physician and where it took place. He was also asked whether he was examined by a physician at regular intervals.

In a section relating to "physician's services in the present illness" and prior to hospital admission, the patient was asked whether and for how long he had been under the care of a private physician; how many office and home visits had been made; whether the physician had called a consultant; whether the patient had consulted more than one physician and, if so, how many of these had been general practitioners and how many specialists. He was also asked to specify the content of any physical examination made by a private physician during the pre-hospital period of this illness.

In the section on "payment for private physician's services for this illness" he was asked whether he (or his family) or some other agency had paid for the physician's services given prior to hospitalization, and whether or not credit had been extended by the physician.

A section on "clinic services prior to hospitalization" for this illness requested information as to whether and for how long clinic care was received, whether the clinic was conducted under public or private auspices and what agency referred the patient to the clinic.

A section on "hospital care for this illness" requested information concerning referral to hospital; whether admitted as an emergency case; whether, in the opinion of the patient, there had been any delay in being admitted to the hospital and the reason for the delay, if any.

The section on "person or agency responsible for hospital care expense" requested a statement from the patient's point of view as to what agency had been responsible for paying for his hospitalization and, if the responsibility had rested on him or his family, whether the bills had been paid by cash, note or in installments. In addition he was asked whether his family physician had cared for him in the hospital and whether he had paid for physician's services in the hospital.

A section on "follow-up service after hospital discharge" requested number of visits to private physicians, to public salaried

physicians, to clinics and by nursing services. The patient was also asked whether he had completed the course of follow-up care recommended.

The final section related to "economic history" and required statements on individual and family annual incomes as well as relief history.

The schedule concluded with a notation of the identity of the person interviewed, the date, the name of the field nurse investigator and her opinion as to whether the information obtained was reliable.

The information called for on Form 2 was secured through personal interviews with patients or their families. These interviews were conducted by seven graduate nurses with special training in public health. It was believed that by confining the field investigation to a small staff of competent investigators the data obtained would be more reliable and uniform than if it had been secured by a larger and less well-trained group.

The nurses made every effort to record the statements as made by the patients. In instances where an interview with the patient could not be arranged or the patient was a minor, the statements of a responsible member of the household were recorded. Frequently several visits to the patient's home were necessary before a personal contact could be made. A time study of the patient interviews showed that the average time for a visit was 40 minutes. The reaction of the patients to questioning was uniformly one of cooperation and interest. Where, in the opinion of a nurse, the person supplying information for Form 2 appeared to be unreliable the data was not utilized in the study.

When the hospital records stated that a ward patient included in the study had been referred to the hospital by a private physician, the referring physician was notified by letter of the scope, purpose and methods of the study and informed of the names of his patients to be visited by the field nurses.

In Table 44 a summary of the present status of patient interviews is presented by hospital.

Extreme difficulty was encountered in completing home visits, particularly in the northern and western rural areas of the State when heavy snow storms caused difficult road conditions. Rather than deviate from the original plan of having only a few nurses complete all of the personal interviews with patients, it was felt advisable to have the same nurses continue the investigation. This necessarily delayed the completion of the field investigation. Interviews with the remaining patients are being continued with approximately one-half of the patient records already completed.

It will be noted that, although a considerable number of the interviews with patients from metropolitan Hospital C had been completed the data from these records were not tabulated in order not to overload the present analysis with urban material.

The analysis of completed patient interviews presented here in tabular form covers six hospitals from five areas. These are so



distributed as to include at least one representative of each type of area under study. The group of hospitals for which personal interview data is provisionally analyzed are all of the voluntary type and therefore one of the variable factors in the entire study is eliminated at this stage.

The completion of the field interviews with patients from six of the hospitals in the study was completed in time to permit a preliminary tabulation of some of the data obtained on Form 2. This was accomplished by means of editing selected items only and summarizing the findings by means of hand tallies. The tallies provide some indication of what this material contains but are in no sense intended to present a final analysis of the wealth of material obtained by means of the field interviews. In the time available, it was impossible to consider all the aspects of each case in a completely coordinated manner. For this reason we must consider provisional the data presented in Tables 63 through 86. Significant correlations obtainable from an adequate study of this data must be postponed until the field investigation is completed and punch cards for the entire series of cases can be prepared and sorted.

### Scope of Provisional Study of Form 2 Data

The information which was edited, coded and tallied for this report consisted of the items selected from Form 2 sections as follows:

**Medical Care:** Intervals as follows between first symptoms of illness which led to hospitalization and first medical attention for that illness; between first medical attention and hospital admission; between first symptom and hospital admission and between hospital application and hospital admission (based on dates for first symptom, first visit by physician for this illness, admission to hospital and application for hospital admission); scene of first medical visit and reason for delay (if any) in securing medical care.

**Self-Medication:** Resort to and type of self-medication together with source of recommendation.

**Physician's Services Prior to Illness Which Led to Hospitalization:** Answer to question "Have you a regular family physician?"; content of physical examination prior to this illness as reported by the patient; whether this examination was for life insurance; whether performed by a private physician and place where it was performed; also, whether physical examinations were performed at periodic intervals.

**Physician's Services in Present Illness and Prior to Hospital Admission:** Period of care by private physician for this illness, whether private physician called a consultant, and content as reported by patient of the physical examination performed by private physician for this illness.

**Payment of Private Physician's Services for This Illness:** Whether patient or some other agency was responsible for paying

for physician's services and, if patient was responsible, whether physician gave credit.

Clinic Services Prior to Hospitalization for This Illness: Period of clinic attendance prior to hospitalization for this illness.

Hospital Care for This Illness: Whether patient felt that there had been delay in being admitted to the hospital.

Person or Agency Responsible for Hospital Care Expense: No data were taken off at this time since this subject had been considered from the hospital and welfare viewpoints in the provisional analysis of Form I data.

Follow-up Services after Hospital Discharge: Physician, clinic, nursing service or institution from which patient received follow-up care following hospital discharge.

Economic History: Individual and family group annual cash incomes reported.

In addition, by comparing date of hospital discharge taken from the hospital records and recorded on Form 1 with date of interview given on Form 2, the interval between leaving the hospital and discussion of medical experience with the nurse investigator was obtained for each case.

Special Handling of Obstetrical Cases: For obstetrical<sup>5</sup> cases an attempt was made to convert all time intervals into months of pregnancy, thus the month of pregnancy in which (1) first medical attention was received, (2) care by private physician began, and (3) care by clinic was commenced were computed. Month of pregnancy in which patient was delivered and place where labor occurred were also obtained. For cases cared for during pregnancy by private physicians, the physical examinations reported were analyzed for the following specific procedures: blood pressure, vaginal examination, urinalysis and blood test for syphilis.

In recording the results of the tallies the cases from each hospital were given separately, except that all obstetrical cases have been removed from the series and presented as an independent group.

### Provisional Findings from Form 2 Data (Obtained by Home Interview)

*Time Intervals* (See Tables 63, 64, 65 and 66 and Chart 13).—A study of the intervals between first symptom of the illness which eventually led to hospitalization as reported by the patient and first medical attention for this illness reveals that in 134 instances (22 per cent) among the 613 for which this interval was obtainable, the medical care began within the first 24 hours. Moreover, of these 134 cases, 56 were admitted to the hospital within the same period. This probably represents a group of acute conditions. At the other extreme a group of 42 patients waited more than five years after first observing symptoms before receiving medical attention. In order to evaluate this information correctly it is obviously nec-

<sup>5</sup> Abortions were considered non-obstetrical in this study because of primary interest in prenatal care.

essary to consider the specific diagnosis for each case and whether the condition was acute or chronic. Such a correlation will be worked out for the complete analysis of this material. It is also necessary to remember in considering the significance of the data so far presented that the hospital admission referred to is not necessarily the first hospitalization period for the illness in question. (A consideration of time intervals for the obstetrical cases is discussed separately below.)

*Interval Between Hospital Application and Hospital Admission* (See Table 68).—Of the 611 patients reporting on the interval between hospital application and admission, 481 (79 per cent) were admitted within 24 hours. The only appreciable waiting times occurred in the metropolitan area included in this study (Hospital D). Not all of the delays indicated difficulty in securing admission to the hospitals since, in some instances, patients preferred to make hospital arrangements in advance for obstetrical care and operations. In no instance was there evidence that an emergency case was delayed in being admitted to the hospital.

*Place Where Patient Received First Medical Attention for Illness Which Led to Hospitalization* (See Table 69).—Forty-five per cent of the 752 patients for whom this information is available were first seen at a physician's office and 31 per cent called physicians to their homes for first medical care in this illness. Seventeen per cent were first seen by a physician in a clinic. It is interesting to note that in metropolitan Area D there were more first visits made both to clinics and to patients' homes than to physicians' offices.

*Patients' Statements as to Reason for Delay (if any), in Securing Medical Care* (See Table 70).—Slightly over half of the 740 patients replying to this question stated that there was delay in securing medical care. Fifty-three per cent of the patients reporting delay in obtaining medical care included among the reasons given that they had not realized the necessity for medical care. Thirty-seven per cent of the patients reporting delay gave inability to pay as one of the reasons. Among the 50 patients of Hospital H who cited delay in obtaining medical attention, one-half gave inability to pay among the reasons. In three instances patients stated that the delay in securing medical attention was due to refusal of welfare officials to authorize care at public expense.

*Self-Medication* (See Table 71).—In Table 71-A the self-medications employed by the 206 patients admitting this practice are analyzed by type of medication use. One hundred four of the 206 patients reporting self-medication mentioned the use of proprietary remedies. Among the 141 obstetrical patients only six reported any form of self-medication. Among the 186 patients who gave the source of the recommendation for self-medication, the majority attributed the suggestion to a member of the family. (See Table 71-B.)



*Family Physician* (See Table 72).—Table 72 reveals that 463, or 60 per cent of the 767 patients reporting, considered that they had regular family physicians. In general it appears from the tabulation that it was more usual to have a regular family physician in rural areas than in cities.

*Physical Examination Prior to This Illness* (See Tables 73 and 74).—Forty and nine-tenths per cent of the patients stated that they had never had a physical examination prior to the illness which led to this hospitalization. An attempt was made to analyze the content of the examinations reported. For the purposes of this tabulation, an examination of all parts of the body with clothes removed, use of stethoscope and recording of blood pressure was considered a complete minimal physical examination. In terms of this definition the examinations of only 137 (32 per cent) of the 423 patients examined met this minimal standard. This corresponds to only 19 per cent of all the patients. In general, the examinations reported from rural areas were less complete than from urban areas.

Fifty-three per cent of the physical examinations reported included at least one laboratory procedure. This corresponds to 30 per cent of the entire group of patients. Forty-three per cent of the examinations reported were performed at clinics, school clinics included, and 33 per cent were performed at physicians' offices (see Table 74). Forty-one per cent of the patients who replied to the question "Was the examination performed by a private physician?" gave affirmative answers. Only 17 of the examinations were reported to have been for life insurance.

*Periodic Physical Examination* (See Table 75).—Only 111 individuals (14 per cent) gave evidence of periodic physical examinations. Of these 67 reported annual examinations. The patients for whom examinations at shorter intervals were reported consisted mainly of infants and diabetics.

*Duration of Private Physician's Care for This Illness* (See Table 76).—Eighty per cent of the patients (obstetrical patients excluded) had been cared for by private physicians during this illness and prior to hospitalization. The largest proportion cared for by private physicians was in rural areas. However, 61 per cent of the patients who reported duration of care by private physicians had received this care for a period of less than one month.

*Private Physician's Use of Consultants* (See Table 77).—Consultants were called by private physicians prior to hospitalization in only 54 cases.

*Content of Physical Examination During This Illness as Reported by Patients* (See Table 78).—The physical examinations performed by private physicians during the illnesses which led to hospitalization were analyzed for content according to the same method as used for physical examinations prior to this illness.

Eighty-six per cent of patients (including obstetrical patients) cared for by private physicians prior to hospitalization reported having had physical examinations of varying content. Inasmuch as some of these patients were sent to the hospital immediately it may be presumed that examinations suitable to the circumstances were performed for these patients upon admission. Of 502 examinations reported only 94 conformed to the definition given above for a complete minimal physical examination. However, laboratory tests were reported in 233 instances. Laboratory procedures were more common for obstetrical patients than for others. Among non-obstetrical patients laboratory tests were most frequently performed for residents of metropolitan Area D.

*Method of Payment for Physician's Services for This Illness and Prior to Hospitalization* (See Table 80).—Four hundred and twenty-seven (73 per cent) of the 585 patients cared for by private physicians stated that they had assumed full responsibility for payment. In addition 12 patients had shared this responsibility with other agencies. Physicians were known to have extended credit to 332 (78 per cent) of the patients assuming full responsibility for payment. Free care by physicians was reported in only 16 cases. Unpaid physicians' bills would undoubtedly raise this to a higher number. It is of interest to note that of the 80 obstetrical patients who were cared for by private physicians 75 (94 per cent) had assumed full responsibility for payment of physicians yet only 24 per cent of these were known to have paid in cash.

*Duration of Clinic Care for This Illness Prior to Hospitalization* (See Table 81).—One hundred and fifty-four patients (24 per cent) of the 630 non-obstetrical patients gave histories of clinic attendance prior to hospitalization. Most of the clinic patients were found in two areas: D and J<sub>2</sub>. Fifty-three per cent of the patients who had attended clinics for periods of known duration had received such care for one month or less.

*Delay in Hospital Admission* (See Table 82).—Seventy-three patients, or 9.6 per cent of the 760 patients reporting on this point, felt that there had been delay in their admission to hospitals. The highest proportion of delays reported by patients occurred in admissions to the hospital in metropolitan Area D.

*Medical Care Following Hospital Discharge* (See Table 83).—Five hundred and fifty-four (74 per cent) of the 745 patients reporting, stated that they had had medical or nursing care after leaving the hospital. Nursing services were received by only 67 (9 per cent) of all surviving patients, and 12 per cent of those receiving any care following hospital discharge. Three hundred and thirty-three patients were seen by private physicians after leaving the hospital and 188 attended clinics. The highest proportion of discharged patients returning to clinics (73 per cent) occurred in the metropolitan area served by Hospital D.

*Family Cash Income* (See Table 85 and Chart 14).—Data concerning family cash income was obtained for 645 of the 771 patients interviewed. For 74 families (11.5 per cent) public relief was the only form of income reported. Seventeen (2.6 per cent) of the families reporting on income appeared to have no cash income whatsoever. Only 230, or 35.7 per cent, of the families reporting on income received \$1,000 or more per year from all sources combined. Cash value of agricultural products has not been estimated. Size of family and number of employed workers per family is not available.

Data on the individual income of the patients hospitalized is shown in Table 84. However, since no correction has been made for children, housewives, and the aged, it is not possible to draw any conclusion from this material.

*Interval Between Hospital Discharge and Interview* (See Table 86).—Table 86 shows that 622 (82 per cent) of the patient interviews took place within six months of hospital discharge.

*Special Analyses of Data on Obstetrical Cases* (See Tables 67 and 79).

*Month of Pregnancy in Which Ante-Partum Care Began* (See Table 67).—Of 141 obstetrical cases, eight received no medical attention prior to hospitalization. Of the 133 patients who received medical attention prior to hospitalization, 80 (60 per cent) received care from private physicians and 63 (47 per cent) were cared for at clinics. These numbers include 10 who were cared for by both clinic and private physician. In Table 67 the month given refers in each instance to the first attention of the kind specified. It should not be assumed that a patient who started care in a specified month of pregnancy continued to receive care from this source throughout her pregnancy.

Three patients received their first medical attention for the pregnancy studied within 24 hours of hospitalization and eight others were not seen by any physician or clinic prior to hospitalization for delivery. Seventy-four, or a little over half, of the obstetrical patients received some medical attention within the first five months of pregnancy. Fifty of these patients were seen by private physicians and 30 were seen in clinics. Six of these patients were known to have been seen by both private physicians and clinics before the sixth month of pregnancy.

*Month of Pregnancy in Which Labor Occurred*.—Of the 137 pregnancies terminated before the end of the hospital period studied only five appear to have terminated earlier than the ninth month of pregnancy. Four obstetrical patients were hospitalized during their pregnancy for the treatment of obstetrical complications and returned to their homes undelivered so that the outcome of these pregnancies remains unknown from the point of view of this study. A review of the obstetrical cases shows only one instance in which a patient was delivered before reaching the hospital and in this case a physician was in attendance.



*Physical Examination by Private Physician During this Pregnancy as Reported by Patient* (See Table 79).—Of the 80 patients seen by private physicians during pregnancy 72 (90 per cent) reported physical examinations. The content of these examinations is analyzed as shown in Table 79. Forty-four per cent of the patients examined reported that all four of the procedures had been performed which for the purpose of this study were considered essential to an ante-partum examination. Blood pressure reading was the most common of these procedures and had been taken on 94 per cent of all the patients examined. Urinalysis was done for 90 per cent of the patients, blood tests for syphilis had been taken on 69 per cent and vaginal examinations had been made in the course of 56 per cent of the examinations.

(Note—Charts 10-14 referred to in this chapter may be found on pages 47-51, above.)

### Summary

A provisional analysis of the data obtained from the hospital and welfare records of the 2,099 patients discharged from the wards of 11 hospitals and 10 representative communities in New York State and interviews by Public Health Nurses with 771 of these patients reveals the following:

1. The proportion of female to male patients was 3 to 2 in all the hospitals studied, but this ratio was higher in the rural hospital wards.

2. Patients of the older age groups were found in greater proportion in the wards of urban hospitals.

3. Conditions of the puerperal state, numerically, made up the largest diagnostic group among the cases studied. Diseases of the digestive system, with appendicitis predominating, formed the second largest group. Diseases of the respiratory system ran third with hypertrophy of the tonsils contributing the majority of these cases.

4. Surgical patients had shorter hospital stays than non-surgical patients.

5. The proportion of patients undergoing surgical procedures tended to be higher in rural than in urban areas.

6. Hospital ward patients for whom public welfare agencies assumed financial responsibility tended to remain in the hospital for longer periods than patients who had to meet hospital charges from their own resources.

7. Ward patients of urban areas turned to public welfare agencies for aid in meeting hospital charges in higher proportion than ward patients of rural areas.

8. Hospital charges for diseases which have a prolonged course such as neoplasms and tuberculosis were more often assumed by welfare agencies than diseases of shorter duration.

9. Surgical and obstetrical patients appeared to have been able to assume full responsibility for their hospital care more often than non-surgical patients.

10. Forty per cent of all the patients were responsible for the payment of their hospital charges.

11. Failure to realize the necessity for medical care and inability to afford a private physician were the predominant reasons given by patients who delayed in securing medical attention.

12. Self-medication was reported by 27 per cent of patients.

13. Patients in rural areas were found to be more likely to have family physicians than patients in urban areas.

14. Only 57 per cent of the ward patients studied reported having had a physical examination before the illness which brought them to the hospital. Periodic physical examinations were reported by only 14 per cent.

15. Of the patients treated prior to hospitalization by a private physician, 73 per cent were responsible for the payment of physician's fees. However, physicians extended credit to 78 per cent of these, indicating that even before hospitalization patients experienced difficulty in meeting medical costs.

16. Twenty-eight per cent of the patients studied gave a history of clinic care for this illness prior to hospitalization.

17. Once application for admission to hospital had been made, there appeared to be no delay in cases in which the need for hospitalization was urgent.

18. Hospital policy in a number of instances prevented the referring physician from treating his patient in the wards.

19. Forty-seven per cent of the obstetrical patients stated that they began their ante-partum care in the sixth month of pregnancy or later. Eight per cent of the obstetrical patients received their first medical attention within 24 hours of admission to the hospital for delivery.

20. Of the obstetrical patients seen by private physicians during pregnancy, 90 per cent reported physical examinations. In 44 per cent of these examinations all four of the following procedures were done: blood pressure, urinalysis, blood test for syphilis and vaginal examination.

21. Three-quarters of the patients discharged from the wards of hospitals stated that they had medical or nursing attention after leaving the hospital. Patients discharged from hospitals in the urban areas received subsequent medical attention in highest proportion.

22. Eleven and five-tenths per cent of the patients interviewed reported that their only form of income was from public relief. Thirty-five and seven-tenths per cent of the families of all patients reporting incomes received \$1,000 or more a year.

## Conclusions

The following conclusions are based on the provisional analysis so far completed:

1. For the patients in the wards of the upstate hospitals studied there appeared to be no appreciable delay in securing admission after application had been made to the hospital.

2. Hospitalization charges for more than half of the ward patients studied were paid from public funds and these patients tended to remain in the hospital for longer periods than patients who assumed their own financial responsibility.

3. The families of 415 ward patients of the 645 ward patients reporting incomes had annual incomes of less than \$1,000. Public relief was the only source of income for 74 of these 415.

4. Although three-quarters of the patients treated by private physicians prior to hospitalization assumed financial responsibility, only one-quarter of these patients paid the physician at the time of treatment.

### New York State (Exclusive of New York City)

#### Study of Patients Discharged from Hospital Wards, 1939

#### DESCRIPTIVE KEY LIST OF HOSPITALS\* SELECTED FOR STUDY

HOSPITAL KEY LETTER	Type of hospital selected	Number of discharged ward cases selected	Type of area served	Special characteristics of area
A.....	Voluntary..	105	Rural	Organized municipal medical care program
B.....	County- state aid..	155	Rural	
C.....	City.....	599	Metropolitan...	
D.....	Voluntary..	304	Metropolitan	
E.....	City.....	155	Urban and sur- rounding rural	
F.....	Voluntary..	125	Urban and sur- rounding rural	Inadequate general hospital facilities; no organized county health department Adequate hospital facilities; organized county health department Organized county depart- ments of health and welfare No organized county health and welfare departments
G.....	Voluntary..	80	Rural industrial	
H.....	Voluntary..	152	Rural.....	
I.....	Voluntary..	165	Rural with sum- mer colony	
J <sub>1</sub> .....	Voluntary..	154	Rural with sum- mer colony	
J <sub>e</sub> .....	Voluntary..	105		

\* Detailed descriptions of each area and hospital given in Tables 42 and 43.



TABLE 42  
New York State (Exclusive of New York City)  
Study of Patients Discharged from Hospital Wards, 1939

DESCRIPTIVE DATA RELATING TO HEALTH AND WELFARE ADMINISTRATION OF COUNTIES IN WHICH HOSPITAL AREAS STUDIED ARE LOCATED TOGETHER WITH PERSONNEL AND FACILITIES FOR MEDICAL CARE

Area	Num-ber of records copied	Type of county	Health department organization	Welfare department organization	Popula-tion per square mile <sup>1</sup>	Public Health Clinics Receiving Public Funds <sup>2</sup>								Welfare policy for hospital-ized cases	Ratio popula-tion per general practi-tioner <sup>3</sup>	Ratio popula-tion per medical special-ist <sup>3</sup>	Num-ber of beds in approved general hos-pitals <sup>3</sup>	Num-ber of approved general hospitals per 1000 popula-tion <sup>3</sup>	Ratio popula-tion per public health nurse <sup>4</sup>	Number of state approved diag-nostic labora-tories <sup>5</sup>
						Child health	Chest	Orthopedic	Veneral disease	Immunization	Maternity, infancy and child hygiene	Dental	General	Other						
A	105	Rural	Local health officers, part-time	Town and city, welfare officers and county com-missioner	38.8	..	..	1	..	..	..	..	..	..	1,079	17,270	83	2.4	34,540	None
B	155	Rural	Local health officers, part-time	Town and city welfare officers and county com-missioner	47.9	2	4	3	1	..	..	..	..	..	757	14,382	135	4.7	14,382	1
C	599	Metro-politan	Organized city health depart-ment, full-time health officer	Town and city welfare officers and county com-missioner	737.3	75	12	6	9	1	18	6	9	123	1,007	3,970	3,229	3.9	17,691	9
D	304	Metro-politan	Organized city health depart-ment, full-time health officer	Town and city welfare officers and county com-missioner	402.2	6	1	2	4	2	6	5	4	1	1,115	3,598	993	4.5	14,871	3
E	155	Urban and sur-rounding rural	Organized city health depart-ment, part-time health officers	Town and city welfare officers and county com-missioner	118.3	9	2	1	2	2	3	..	1	6	1,282	5,501	299	2.2	12,002	4

F	125	Urban and suburban and surrounding rural	Local health officer, part-time	Town and city welfare officers and county commissioner	83.5	2	1	1	1	1	1	700	12.7	9,462	2
G	80	Rural industrial	Local health officer, part-time	Town and city welfare officers and county commissioner	43.9	4	1	1	1	1	1	119	1.8	9,252	None
H	152	Rural . . .	Local health officer, part-time	Town and city welfare officers and county commissioner	63.0	1	1	1	1	1	1	154	4.7	6,563	1
I	165	Rural with summer colony	Organized county health department, full-time health officer	Organized county welfare department	175.1	7	7	7	7	7	7	693	4.1	9,945	4
J	259	Rural with summer colony	Local health officers, part-time	Town and city welfare officers and county commissioner	156.3	5	6	4	3	2	2	795	6.0	7,342	2

<sup>1</sup> Decennial Census of the United States 1930, Vol. 1, p. 749.

<sup>2</sup> Data from "Facilities for Medical Care," file, New York State Dept. of Health, July 1, 1938.

<sup>3</sup> Data from Preliminary Report of the New York State Temporary Legislative Commission to Formulate a Long Range State Health Program, May 15, 1939.

(Leg. Doc. No. 97).

<sup>4</sup> Engaged in, "generalized public health nursing program. Data from Leg. Doc. No. 97, p. 27.

<sup>5</sup> Data from "Local Laboratory Service, Approved Laboratories," New York State Dept. of Health, May 24, 1939.

<sup>6</sup> Conducts clinics.

<sup>7</sup> Dates and places not fixed.

TABLE 43  
New York State (Exclusive of New York City)  
Study of Patients Discharged from Hospital Wards, 1939  
FACTS CONCERNING HOSPITALS IN STUDY

AREA	No. of records copied	Control	Beds (exclusive of bassinets) <sup>1</sup>	Average daily census 1938 <sup>1</sup>	Annual admissions 1938 <sup>1</sup>	General staff	Ward staff	Out-patient department	Social service department	Remarks
A	105	Voluntary	68	37	1,368	Semi-closed	None	None	None	Records very brief and many uncompleted
B	155	County — state aid	112	85	2,518	Closed	Rotating	Yes	None	Records well kept and complete; 8 full time paid staff members; non-salaried part-time staff in addition
C	599	City	1,025	862	10,543	Closed	Rotating	Complete	Professional	Police calls excluded from series; medical care program includes full time and part time ward and hospital OPD physicians; records filed by unit system, complete and well kept
D	304	Voluntary	593	540	12,062	Closed	Rotating	Complete	Professional	Records well written and filed by unit system
E	155	City	100	75	3,500	Closed	Rotating	None	None	City physician and surgeon permitted to treat city patients on wards; records brief
F	125	Voluntary	97	48	1,643	Closed	None	None	None	Records well written and filed by unit system; full time record librarian
G	80	Voluntary	31	29	821	Open	Rotating	None	None	Records brief and many uncompleted
H	152	Voluntary	133	95	3,023	Closed	Rotating	None	None	
I	165	Voluntary	101	43	1,897	Closed	Rotating	None	None	Records complete and well kept
J <sup>1</sup>	134	Voluntary	90	69	2,079	Closed	Rotating	Prenatal; ENT; tumor	Volunteer	
J <sup>2</sup>	105	Voluntary	61	39	1,480	Closed	Rotating	Pediatric; ENT; tumor	None	Records brief

<sup>1</sup> Data from Journal of American Medical Association, March 11, 1939, Vol. 112, No. 10.



TABLE 44  
New York State (Exclusive of New York City)  
Study of Patients Discharged from Hospital Wards, 1939  
STATUS OF INTERVIEWS AS OF MARCH 15, 1940 BY HOSPITAL<sup>1</sup>

	All hos- pitals	Hos- pital A <sup>2</sup>	Hos- pital B	Hos- pital C	Hos- pital D <sup>3</sup>	Hos- pital E	Hos- pital F <sup>4</sup>	Hos- pital G	Hos- pital H <sup>5</sup>	Hos- pital I	Hos- pital J <sup>6</sup>	Hos- pital J <sup>7</sup>
Hospital records copied on Form 1.....	2,099	105	155	599	304	155	125	80	152	165	154	105
Interviews completed on Form 2.....	1,048	92	17	200	234	.....	105	.....	117	60	132	91
Percent interviews obtained.....	.....	87.6	.....	.....	77.0	.....	84.0	.....	77.0	.....	85.7	86.7
Number of Form 2, obstetrical cases excluded.....	630	76	.....	.....	192	.....	85	.....	94	.....	108	75
Number of Form 2, obstetrical cases.....	141	16	.....	.....	42	.....	20	.....	23	.....	24	16
Interviews not obtained.....	174	13	.....	.....	70	.....	20	.....	35	.....	22	14
Not home or no appropriate informant.....	15	2	.....	.....	7	.....	48	.....	3	.....	.....	.....
Not found.....	49	5	.....	.....	21	.....	7	.....	16	.....	.....	.....
Moved.....	68	4	.....	.....	42	.....	7	.....	13	.....	.....	.....
Reside out of area.....	5	1	.....	.....	.....	.....	1	.....	3	.....	.....	.....
Unknown reason.....	37	1	.....	.....	.....	.....	2	.....	.....	.....	.....	.....
												12

<sup>1</sup> See descriptive key list of hospitals on page 219.

<sup>2</sup> Indicates hospitals for which provisional Form 2 data has been presented.

<sup>3</sup> Estimated — field investigation in progress.

<sup>4</sup> Includes one patient in county home.

<sup>5</sup> Includes one case in which field investigator was refused admission.

TABLE 45

New York State (Exclusive of New York City)

Study of Patients Discharged from Hospital Wards, 1939

2,099 HOSPITAL AND WELFARE RECORDS FROM 11 HOSPITALS SERVING 10 REPRESENTATIVE COMMUNITIES CLASSIFIED BY (A) AGE, (B) SEX, (C) CIVIL STATUS, AND (D) OCCUPATIONAL GROUP BY HOSPITAL<sup>1</sup>

	All hospitals (1)	Hos-pital A (2)	Hos-pital B (3)	Hos-pital C (4)	Hos-pital D (5)	Hos-pital E (6)	Hos-pital F (7)	Hos-pital G (8)	Hos-pital H (9)	Hos-pital I (10)	Hos-pital J (11)	Hos-pital K (12)
(A) — Age												
Total	2,099	105	155	599	304	155	125	80	152	165	154	105
Age												
Under 1 year	49	3	3	11	9	3	1	1	6	1	10	1
1 year and under 2 years	27	3	4	3	2	3	1	.....	4	1	4	2
2 years and under 5	86	2	6	31	14	1	3	.....	7	3	7	10
5 years and under 10	174	9	5	42	20	9	7	8	23	25	9	17
10 years and under 15	138	5	15	28	25	10	4	4	18	8	9	12
15 years and under 20	174	17	10	38	22	17	15	10	15	16	10	4
20 years and under 25	254	11	24	50	38	19	19	13	24	32	21	17
25 years and under 35	365	25	25	90	56	34	26	16	17	33	26	10
35 years and under 45	263	15	16	104	39	14	15	10	8	17	15	10
45 years and under 55	226	4	19	91	32	17	11	6	10	9	17	10
55 years and under 65	152	4	8	54	25	8	9	4	10	10	17	7
65 years and over	191	7	20	57	22	20	14	6	14	10	9	12
(B) — Sex												
Sex												
Male	880	38	73	313	131	60	44	23	25	58	52	36
Female	1,219	67	82	286	173	95	81	57	100	107	102	69
(C) — CIVIL STATUS												
Not reported	141	16	5	13	62	5	8	2	16	4	5	5
Reported	1,958	89	130	586	242	150	117	78	136	161	149	106
Single	755	39	51	209	98	47	43	30	73	63	55	47
Married	979	47	85	279	115	86	64	40	52	88	83	40
Widowed	146	2	11	63	13	9	7	7	5	8	9	12
Divorced	10	.....	.....	3	4	2	.....	.....	.....	.....	1	.....
Separated	68	1	3	32	12	6	3	1	6	2	1	1

(D) — OCCUPATIONAL GROUP	250	6	10	58	19	24	31	15	8	22	53	4
Not reported.....	1,849	99	143	541	285	131	94	65	144	143	101	101
Reported.....												
Professional and semi-pro-												
fessional.....	22	2	2	12	1	1	1	1	.....	1	.....	1
White collar.....	14	.....	.....	6	5	3	.....	.....	.....	.....	.....	.....
Trade (proprietor and sales).....	27	1	1	13	6	2	.....	.....	1	1	.....	.....
Agriculture.....	51	6	18	8	9	1	2	1	4	1	.....	1
Industrial.....	229	14	18	123	29	19	12	1	7	2	.....	4
Transportation.....	28	3	1	11	6	2	3	.....	.....	1	.....	1
Domestic service.....	61	6	4	19	10	3	6	.....	4	4	2	2
Housewife.....	722	35	56	172	103	56	43	36	50	78	55	38
Non-worker.....	618	27	44	152	90	41	23	21	75	52	42	51
Unemployed.....	77	5	1	25	26	3	4	3	3	3	1	3

<sup>1</sup> See descriptive list of hospitals on page 219.

<sup>2</sup> Of the 2,699 reporting 1,973 were White, 120 Negro, 1 Chinese and 5 Indian.



TABLE 46  
New York State (Exclusive of New York City)  
Study of Patients Discharged from Hospital Wards, 1939  
2,099 HOSPITAL AND WELFARE RECORDS FROM 11 HOSPITALS SERVING 10 REPRESENTATIVE COMMUNITIES CLASSIFIED  
BY LENGTH OF STAY IN HOSPITAL BY SURGERY BY AREA

LENGTH OF HOSPITAL STAY	ALL HOSPITALS (1)		HOSPITAL A (2)		HOSPITAL B (3)		HOSPITAL C (4)		HOSPITAL D (5)		HOSPITAL E (6)	
	Number	Percent	Number	Percent	Number	Percent	Number	Percent	Number	Percent	Number	Percent
All patients.....	2,099		105		155		599		304		155	
Not reported.....	6		1		.....		4		1		.....	
Total.....	2,093	100.0	104	100.0	155	100.0	595	100.0	303	100.0	155	100.0
Under 1 day.....	42		2		1		8		.....		5	
1 day and under 3 days.....	299		5		15		24		45		41	
3 days and under 1 week.....	337		19		32		78		48		32	
1 week and under 2 weeks.....	718		40		57		180		90		44	
2 weeks and under 3.....	294		21		17		98		51		26	
3 weeks and under 4.....	145		3		11		77		27		3	
4 weeks and under 5.....	183		6		6		40		10		8	
5 weeks and under 6.....	49		2		4		26		6		1	
6 weeks and under 7.....	23		2		1		10		5		.....	
7 weeks and under 8.....	15		.....		2		6		4		.....	
8 weeks and under 12 weeks.....	46		3		5		24		8		.....	
12 weeks and under 16.....	19		1		2		13		3		.....	
16 weeks and under 20.....	4		.....		.....		.....		.....		.....	
20 weeks and under 24.....	4		.....		.....		3		.....		.....	
24 weeks and over.....	15		.....		2		7		1		.....	

Surgery	843	40.3	52	50.0	33	24.5	176	29.6	104	34.3	76	49.0
Under 1 day	21		2		.....		.....		.....		2	
1 day and under 3 days	202		3		4		7		29		24	
3 days and under 1 week	108		3		6		37		13		6	
1 week and under 2 weeks	233		16		13		60		19		20	
2 weeks and under 3	143		16		4		28		19		21	
3 weeks and under 4	47		2		5		15		12		.....	
4 weeks and under 5	36		2		2		4		3		2	
5 weeks and under 6	22		2		.....		8		2		1	
6 weeks and under 7	9		.....		1		3		1		.....	
7 weeks and under 8	8		.....		1		2		2		.....	
8 weeks and under 12 weeks	16		3		1		7		2		.....	
12 weeks and under 16	6		.....		1		5		.....		.....	
16 weeks and under 20	.....		.....		.....		.....		.....		.....	
20 weeks and under 24	.....		.....		.....		.....		.....		.....	
24 weeks and over	2		.....		.....		.....		.....		.....	
Non-surgery	1,178	56.3	51	49.0	104	67.1	397	66.7	194	64.0	77	49.7
Under 1 day	21		.....		1		8		.....		3	
1 day and under 3 days	90		1		9		15		15		17	
3 days and under 1 week	212		16		20		39		34		25	
1 week and less than 2 weeks	463		24		42		110		71		23	
2 weeks and under 3	141		5		13		66		30		5	
3 weeks and under 4	90		1		4		59		30		3	
4 weeks and under 5	53		1		4		35		17		.....	
5 weeks and under 6	27		.....		4		18		4		1	
6 weeks and under 7	14		2		.....		7		4		.....	
7 weeks and under 8	7		.....		1		4		2		.....	
8 weeks and under 12 weeks	26		.....		3		15		6		.....	
12 weeks and under 16	13		1		1		8		3		.....	
16 weeks and under 20	4		.....		.....		3		.....		.....	
20 weeks and under 24	4		.....		.....		3		1		.....	
24 weeks and over	13		.....		2		7		3		.....	

TABLE 46 — (Continued)

LENGTH OF HOSPITAL STAY	ALL HOSPITALS (1)	HOSPITAL A (2)	HOSPITAL B (3)	HOSPITAL C (4)	HOSPITAL D (5)	HOSPITAL E (6)
	Number Percent	Number Percent	Number Percent	Number Percent	Number Percent	Number Percent
Surgery unknown.....	72 3.4	1 1.0	13 8.4	22 3.7	5 1.7	2 1.3
Under 1 day.....	7	1	2	2	1	1
1 day and under 3 days.....	17	1	6	2	1	1
3 days and under 1 week.....						
1 week and under 2 weeks.....	22		2	10		1
2 weeks and under 3 weeks.....	10		2	2	2	
3 weeks and under 4 weeks.....	8		2	3	1	
4 weeks and under 5 weeks.....	4			1		
5 weeks and under 6 weeks.....						
6 weeks and under 7 weeks.....						
7 weeks and under 8 weeks.....						
8 weeks and under 12 weeks.....	4		1	2		
12 weeks and under 16 weeks.....						
16 weeks and under 20 weeks.....						
20 weeks and under 24 weeks.....						
24 weeks and over.....						

1 See descriptive key list of hospitals on page 219.

2 Six cases not for length of hospital stay include 3 with and 3 without surgery



TABLE 46 — (Continued)

	HOSPITAL F (7)	HOSPITAL G (8)	HOSPITAL H (9)	HOSPITAL I (10)	HOSPITAL J <sub>i</sub> (11)	HOSPITAL J <sub>j</sub> (12)
	Number    Percent	Number    Percent	Number    Percent	Number    Percent	Number    Percent	Number    Percent
All patients.....	125 .....	80 .....	152 .....	165 .....	154 .....	105 .....
Not reported.....	125 100.0	80 100.0	152 100.0	165 100.0	154 100.0	105 100.0
Total.....	125 .....	80 .....	152 .....	165 .....	154 .....	105 .....
Under 1 day.....	13	2	13	3	3	4
1 day and under 3 days.....	35	14	35	48	22	39
3 days and under 1 week.....	25	7	14	27	40	15
- 1 week and under 2 weeks.....	54	39	56	72	59	27
2 weeks and under 3.....	16	13	20	8	18	;
3 weeks and under 4.....	6	2	3	4	4	5
4 weeks and under 5.....	6	3	3	2	1	3
5 weeks and under 6.....	2	..	2	1	4	1
6 weeks and under 7.....	..	..	2	..	1	2
7 weeks and under 8.....	..	..	..	1	1	1
8 weeks and under 12 weeks.....	2	..	2	1	1	..
12 weeks and under 16.....	..	..	..	..	..	..
16 weeks and under 20.....	..	..	1	..	..	..
20 weeks and under 24.....	..	..	..	..	..	..
24 weeks and over.....	..	..	1	..	..	..
Surgery.....	78 62.4	44 55.0	76 50.0	77 46.7	59 38.3	63 60.0
Under 1 day.....	1	1	12	2	..	1
1 day and under 3 days.....	9	13	31	35	10	37
3 days and under 1 week.....	14	2	..	12	8	7
1 week and under 2 weeks.....	29	17	12	18	22	7
2 weeks and under 3.....	14	7	14	5	10	5
3 weeks and under 4.....	3	2	3	1	2	2
4 weeks and under 5.....	5	2	1	1	..	1
5 weeks and under 6.....	2	..	2	1	4	0
6 weeks and under 7.....	..	..	1	..	1	2
7 weeks and under 8.....	..	..	..	1	1	1
8 weeks and under 12 weeks.....	1	..	..	1	1	..
12 weeks and under 16.....	..	..	..	..	..	..
16 weeks and under 20.....	..	..	..	..	..	..
20 weeks and under 24.....	..	..	..	..	..	..
24 weeks and over.....	..	..	..	..	..	..

TABLE 46—(Concluded)

LENGTH OF HOSPITAL STAY	HOSPITAL F (7)		HOSPITAL G (8)		HOSPITAL H (9)		HOSPITAL I (10)		HOSPITAL J <sub>1</sub> (11)		HOSPITAL J <sub>2</sub> (12)	
	Number	Percent	Number	Percent	Number	Percent	Number	Percent	Number	Percent	Number	Percent
Non-surgery.....	40	32.0	33	41.2	70	46.1	84	50.9	89	57.8	39	37.1
Under 1 day.....	.....	.....	1	.....	1	.....	1	.....	3	.....	3	.....
1 day and under 3 days.....	4	.....	1	.....	4	.....	11	.....	11	.....	2	.....
3 days and under 1 week.....	9	.....	5	.....	13	.....	13	.....	31	.....	7	.....
1 week and under 2 weeks.....	23	.....	22	.....	42	.....	53	.....	33	.....	20	.....
2 weeks and under 3.....	2	.....	4	.....	5	.....	2	.....	8	.....	1	.....
3 weeks and under 4.....	1	.....	.....	.....	.....	.....	3	.....	2	.....	3	.....
4 weeks and under 5.....	.....	.....	.....	.....	1	.....	1	.....	1	.....	2	.....
5 weeks and under 6.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	1	.....
6 weeks and under 7.....	.....	.....	.....	.....	1	.....	.....	.....	.....	.....	.....	.....
7 weeks and under 8.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....
8 weeks and under 12 weeks.....	1	.....	.....	.....	1	.....	.....	.....	.....	.....	.....	.....
12 weeks and under 16.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....
16 weeks and under 20.....	.....	.....	.....	.....	1	.....	.....	.....	.....	.....	.....	.....
20 weeks and under 24.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....
24 weeks and over.....	.....	.....	.....	.....	1	.....	.....	.....	.....	.....	.....	.....
Surgery unknown.....	7	5.6	3	3.8	6	3.9	4	2.4	6	3.9	3	2.9
Under 1 day.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....
1 day and under 3 days.....	.....	.....	.....	.....	1	.....	.....	.....	.....	.....	.....	.....
3 days and under 1 week.....	2	.....	.....	.....	.....	.....	2	.....	1	.....	1	.....
1 week and under 2 weeks.....	2	.....	.....	.....	2	.....	1	.....	4	.....	2	.....
2 weeks and under 3.....	.....	.....	2	.....	1	.....	.....	.....	.....	.....	.....	.....
3 weeks and under 4.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....
4 weeks and under 5.....	.....	.....	1	.....	.....	.....	.....	.....	.....	.....	.....	.....
5 weeks and under 6.....	1	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....
6 weeks and under 7.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....
7 weeks and under 8.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....
8 weeks and under 12 weeks.....	.....	.....	.....	.....	1	.....	.....	.....	.....	.....	.....	.....
12 weeks and under 16.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....
16 weeks and under 20.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....
20 weeks and under 24.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....
24 weeks and over.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....

1 See descriptive key list of hospitals on page 219.

2 Six cases not for length of hospital stay include 3 with and 3 without surgery.

TABLE 47

New York State (Exclusive of New York City)

Study of Patients Discharged from Hospital Wards, 1939

2,099 HOSPITAL AND WELFARE RECORDS FROM 11 HOSPITALS SERVING  
10 REPRESENTATIVE COMMUNITIES CLASSIFIED BY LENGTH OF  
STAY IN HOSPITAL BY SURGERY

LENGTH OF HOSPITAL STAY	Total	Surgery	Non- surgery	Surgery unknown
Total cases.....	2,099	846	1,181	72
Not reported.....	6	3	3	.....
Reported.....	2,093	843	1,178	72
Under 1 day.....	42	21	21	.....
1 day and under 3 days.....	299	202	90	7
3 days and under 1 week.....	337	108	212	17
1 week and under 2 weeks.....	718	233	463	22
2 weeks and under 3.....	294	143	141	10
3 weeks and under 4.....	145	47	90	8
4 weeks and under 6.....	132	48	80	4
6 weeks and under 8.....	38	17	21	.....
8 weeks and over.....	88	24	60	4



TABLE 48

New York State (Exclusive of New York City)

Study of Patients Discharged from Hospital Wards, 1939

CASES,<sup>2</sup> PERCENT SURGERY, ESTIMATED HOSPITAL DAYS,<sup>3</sup> MEAN AND MEDIAN LENGTH OF STAY IN HOSPITAL STUDIED BY SURGERY BY HOSPITAL<sup>1</sup>

SURGERY	ALL HOSPITALS					HOSPITAL A					HOSPITAL B					HOSPITAL C				
	Cases	Per cent	Esti- mated hospital days	Mean length of stay	Median length of stay	Cases	Per cent	Esti- mated hospital days	Mean length of stay	Median length of stay	Cases	Per cent	Esti- mated hospital days	Mean length of stay	Median length of stay	Cases	Per cent	Esti- mated hospital days	Mean length of stay	Median length of stay
Total.....	2,003	100.0	33,329.0	15.92	10.59	104	100.0	1,584.0	15.23	11.55	155	100.0	2,698.0	17.41	10.62	595	100.0	13,983.0	23.50	14.55
Surgery.....	843	40.3	11,239.5	13.33	9.72	52	50.0	942.0	18.12	14.88	38	24.5	657.0	17.29	11.85	176	29.6	3,197.0	18.16	12.13
Non-surgery.....	1,178	59.3	21,051.5	17.87	11.02	51	49.0	640.5	12.56	9.48	104	67.1	1,884.0	18.12	10.67	367	66.7	10,410.0	26.22	16.86
Surgery unknown.....	72	3.4	1,038.0	14.42	10.82	1	1.0	1.5	1.50	1.50	13	8.4	157.0	12.08	6.00	22	3.7	376.0	17.09	11.90
HOSPITAL D																				
Total.....	303	100.0	5,875.5	19.39	11.55	155	100.0	1,293.0	8.34	6.94	125	100.0	1,473.5	11.79	10.05	80	100.0	805.5	10.07	10.05
Surgery.....	104	34.3	1,846.0	17.75	10.68	76	49.0	721.0	9.49	9.10	78	62.4	972.0	12.46	10.62	44	55.0	428.0	9.73	9.47
Non-surgery.....	194	64.0	3,965.5	20.44	11.78	77	49.7	557.5	7.24	5.96	40	32.0	393.5	9.84	9.13	33	41.2	312.5	9.47	10.02
Surgery unknown.....	5	1.7	64.0	12.80	15.73	2	1.3	14.5	7.25	7.00	7	5.6	108.0	15.43	12.25	3	3.8	65.0	21.67	19.25
HOSPITAL E																				
Total.....	152	100.0	1,784.0	11.74	8.75	165	100.0	1,360.0	8.24	7.63	154	100.0	1,545.5	10.04	7.83	105	100.0	927.0	8.83	5.53
Surgery.....	76	50.0	634.5	8.35	2.68	77	46.7	581.5	7.55	3.50	59	38.3	703.0	13.51	10.66	63	60.0	463.5	7.36	2.92
Non-surgery.....	70	46.1	1,018.0	14.54	9.83	84	50.9	742.5	8.84	9.25	89	57.8	707.5	7.89	6.94	39	37.1	425.0	10.90	9.63
Surgery unknown.....	6	3.9	131.5	21.92	14.00	4	2.4	36.0	9.00	7.00	6	3.9	46.0	7.67	8.75	3	2.9	38.5	12.83	15.75

<sup>1</sup> See descriptive key list of hospitals on page 219.<sup>2</sup> Six cases not reported for length of hospital stay omitted from table.<sup>3</sup> Estimated from grouped data.

TABLE 49

New York State (Exclusive of New York City)

Study of Patients Discharged from Hospital Wards, 1939

CASES,<sup>1</sup> PERCENT SURGERY, ESTIMATED HOSPITAL DAYS,<sup>2</sup> MEAN AND MEDIAN LENGTH OF STAY IN HOSPITAL STUDIED BY SURGERY

SURGERY	Cases	Percent	Estimated hospital days	Mean length of stay	Median length of stay
Total .....	2,093	100.0	33,329.0	15.92	10.59
Surgery .....	843	40.3	11,239.5	13.33	9.72
Non-surgery .....	1,178	56.3	21,051.5	17.87	11.02
Surgery unknown .....	72	3.4	1,038.0	14.42	10.82

<sup>1</sup> Six cases not reported for length of hospital stay omitted from table.<sup>2</sup> Estimated from grouped data.

TABLE 50  
New York State (Exclusive of New York City)  
Study of Patients Discharged from Hospital Wards, 1939

833 CASES FOR WHICH PATIENT AND 1,055 CASES FOR WHICH PUBLIC WELFARE AGENCY WAS RESPONSIBLE FOR PAYMENT OF HOSPITAL CHARGES, AMONG 2,099 HOSPITAL WARD PATIENTS FROM 11 HOSPITALS SERVING 10 REPRESENTATIVE COMMUNITIES, CLASSIFIED BY LENGTH OF STAY IN HOSPITAL, BY HOSPITAL<sup>1</sup>

LENGTH OF HOSPITAL STAY	ALL HOSPITALS		HOSPITAL A		HOSPITAL B		HOSPITAL C		HOSPITAL D		HOSPITAL E		HOSPITAL F		HOSPITAL G		HOSPITAL H		HOSPITAL I		HOSPITAL J <sub>1</sub>		HOSPITAL J <sub>2</sub>	
	Pat.	Pub. wel.	Pat.	Pub. wel.	Pat.	Pub. wel.	Pat.	Pub. wel.	Pat.	Pub. wel.	Pat.	Pub. wel.	Pat.	Pub. wel.	Pat.	Pub. wel.	Pat.	Pub. wel.	Pat.	Pub. wel.	Pat.	Pub. wel.	Pat.	Pub. wel.
Total.....	833	1,055	65	36	64	89	56	380	56	239	103	47	98	26	53	25	58	85	111	44	108	44	61	40
Not reported.....	2	4	1	...	...	...	4	1	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...
Reported.....	831	1,051	64	36	64	89	56	376	55	239	103	47	98	26	53	25	58	85	111	44	108	44	61	40
Under 1 day.....	28	9	2	...	...	1	4	2	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...
1 day and under 3 days.....	181	103	4	1	9	6	10	10	16	27	29	11	12	1	11	3	21	11	31	12	14	8	1	13
3 days and under 1 week.....	149	151	12	7	15	17	11	37	9	37	21	11	19	6	5	1	2	12	15	10	32	6	8	7
1 week and under 2 weeks.....	332	327	30	10	25	31	15	115	20	69	33	10	47	7	30	9	20	34	52	16	43	16	17	10
2 weeks and under 3 weeks.....	80	187	5	13	6	10	6	73	8	42	13	11	11	4	4	9	4	15	6	1	11	7	6	2
3 weeks and under 4 weeks.....	25	95	2	1	4	7	6	48	1	25	1	2	4	2	1	1	1	2	1	3	2	2	3	2
4 weeks and under 5 weeks.....	13	56	5	1	1	5	2	29	...	8	1	2	4	2	1	2	1	2	1	2	2	2	3	1
5 weeks and under 6 weeks.....	9	27	1	...	2	2	2	13	...	5	...	1	1	...	...	...	...	2	...	...	2	2	...	...
6 weeks and under 7 weeks.....	4	17	...	2	...	1	1	7	...	5	...	...	...	...	...	...	...	2	...	...	1	...	...	...
7 weeks and under 8 weeks.....	2	11	...	...	...	2	...	4	...	4	...	...	...	...	...	...	...	...	1	...	1	...	...	...
8 weeks and under 12 weeks.....	6	33	2	1	2	3	...	18	1	7	...	...	...	2	...	...	...	1	1	...	...	1	...	...
12 weeks and under 16 weeks.....	2	14	1	...	...	2	...	9	...	8	...	...	...	...	...	...	...	...	...	...	...	...	...	...
16 weeks and under 20 weeks.....	...	3	...	...	...	...	...	2	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...
20 weeks and under 24 weeks.....	...	2	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...
24 weeks and over.....	...	15	...	...	...	2	...	7	...	5	...	...	...	...	...	...	...	...	...	...	...	...	...	...

<sup>1</sup> See descriptive key list of hospitals on page 219.



TABLE 51

New York State (Exclusive of New York City)

Study of Patients Discharged from Hospital Wards, 1939

833 CASES FOR WHICH PATIENT AND 1,055 CASES FOR WHICH PUBLIC WELFARE AGENCY WAS RESPONSIBLE FOR PAYMENT OF HOSPITAL CHARGES, AMONG 2,099 HOSPITAL WARD PATIENTS FROM 11 HOSPITALS SERVING 10 REPRESENTATIVE COMMUNITIES, CLASSIFIED BY LENGTH OF STAY IN HOSPITAL

LENGTH OF HOSPITAL STAY	PATIENT RESPONSIBLE		PUBLIC WELFARE AGENCY RESPONSIBLE	
	Number	Percent	Number	Percent
Total.....	833	.....	1,055	.....
Not reported.....	2	.....	4	.....
Reported.....	831	100.0	1,051	100.0
Under 1 day.....	28	3.4	9	0.8
1 day and under 3 days.....	181	21.8	103	9.8
3 days and under 1 week.....	149	17.9	151	14.4
1 week and under 2 weeks.....	332	40.0	327	31.1
2 weeks and under 3.....	80	9.6	187	17.8
3 weeks and under 4.....	25	3.0	95	9.0
4 weeks and under 6.....	22	2.6	83	7.9
6 weeks and under 8.....	6	0.7	28	2.7
8 weeks and over.....	8	1.0	68	6.5

TABLE 52

## New York State (Exclusive of New York City)

## Study of Patients Discharged from Hospital Wards, 1939

CASES, ESTIMATED HOSPITAL DAYS,<sup>2</sup> MEAN AND MEDIAN LENGTH OF STAY IN HOSPITAL FOR 1,882 CASES FOR WHICH PATIENT OR PUBLIC WELFARE AGENCY WAS RESPONSIBLE FOR HOSPITAL CHARGES AMONG 2,099 HOSPITAL WARD PATIENTS FROM 11 HOSPITALS<sup>1</sup> SERVING 10 REPRESENTATIVE COMMUNITIES BY HOSPITAL

	All hos- pitals	Hos- pital A	Hos- pital B	Hos- pital C	Hos- pital D	Hos- pital E	Hos- pital F	Hos- pital G	Hos- pital H	Hos- pital I	Hos- pital J <sub>1</sub>	Hos- pital J <sub>2</sub>
<i>Patient Responsible</i>												
Cases.....	<sup>3</sup> 831	64	64	56	55	103	98	53	53	111	108	61
Estimated hospital days.....	7,862.0	919.0	775.0	667.5	502.5	746.5	1,018.5	439.0	368.0	915.5	1,004.0	506.5
Mean length of stay.....	9.46	14.36	12.11	11.92	9.14	7.25	10.39	8.28	6.34	8.25	9.30	8.30
Median length of stay.....	8.21	10.26	9.24	8.40	7.88	6.33	9.68	8.98	2.90	7.86	7.98	5.75
<i>Public Welfare Responsible</i>												
Cases.....	<sup>4</sup> 1,051	36	89	376	239	47	26	25	85	44	44	40
Estimated hospital days.....	21,465.5	576.0	1,896.0	9,903.5	5,248.0	463.0	438.0	338.0	1,280.0	374.0	532.3	416.5
Mean length of stay.....	20.42	16.00	21.30	26.34	21.96	9.85	16.85	13.52	15.06	8.50	12.10	10.41
Median length of stay.....	12.62	14.00	11.63	16.30	11.23	8.05	12.00	13.61	10.40	7.00	10.06	6.43

<sup>1</sup> See descriptive key list of hospitals on page 219.

<sup>2</sup> Estimated from grouped data.

<sup>3</sup> Two cases not reported for length of stay omitted from calculation.

<sup>4</sup> Four cases not reported for length of stay omitted from calculation.

TABLE 53  
New York State (Exclusive of New York City)  
Study of Patients Discharged from Hospital Wards, 1939

2,099 HOSPITAL AND WELFARE RECORDS FROM 11 HOSPITALS SERVING 10 REPRESENTATIVE COMMUNITIES  
CLASSIFIED BY DIAGNOSTIC GROUP BY SURGERY BY HOSPITAL<sup>1</sup>

DIAGNOSTIC GROUP	All hos- pitals	Hos- pital A	Hos- pital B	Hos- pital C	Hos- pital D	Hos- pital E	Hos- pital F	Hos- pital G	Hos- pital H	Hos- pital I	Hos- pital J <sub>1</sub>	Hos- pital J <sub>2</sub>
Total.....	2,099	105	155	599	304	155	125	80	152	165	154	105
Non-surgery.....	1,181	52	104	399	194	77	40	33	70	84	89	39
Surgery.....	846	52	38	178	105	76	78	44	76	77	59	63
Surgery unknown.....	72	1	13	22	5	2	5	3	6	4	6	3
Infectious diseases.....	164	3	17	101	25	4	3	1	4	2	4	4
Non-surgery.....	155	3	17	98	20	4	2	1	4	2	4	4
Surgery.....	9	.....	.....	3	5	.....	1	.....	.....	.....	.....	.....
Surgery unknown.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....
Neoplasms.....	123	.....	5	42	22	9	5	2	2	8	12	16
Non-surgery.....	78	.....	2	18	11	2	1	.....	1	4	3	6
Surgery.....	44	.....	3	23	11	7	4	2	1	4	9	10
Surgery unknown.....	74	.....	.....	1	.....	.....	.....	.....	.....	.....	.....	.....
Rheumatic diseases, disorders of metabolism and endocrine glands, vitamin deficiencies.....	93	5	9	34	8	13	4	2	2	5	8	3
Non-surgery.....	78	4	7	31	8	9	4	1	2	4	8	.....
Surgery.....	15	1	2	3	.....	4	.....	.....	.....	1	.....	3
Surgery unknown.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....
Traumatic conditions, poisonings.....	40	3	3	13	7	3	1	2	2	.....	5	1
Non-surgery.....	30	3	2	8	6	3	1	1	2	.....	3	1
Surgery.....	7	.....	.....	5	.....	.....	.....	.....	.....	.....	2	.....
Surgery unknown.....	3	.....	.....	1	.....	.....	.....	.....	.....	.....	.....	.....
Puerperal state.....	390	24	32	72	57	29	25	1	32	53	27	19
Non-surgery.....	349	21	26	61	53	25	21	20	32	49	26	16
Surgery.....	35	3	2	10	4	4	4	1	.....	4	1	2
Surgery unknown.....	36	.....	4	1	.....	.....	.....	.....	.....	.....	.....	1
Neurological and psychiatric conditions.....	47	1	2	18	8	8	1	1	4	2	1	1
Non-surgery.....	46	1	2	18	8	8	.....	1	.....	2	1	1
Surgery.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....
Surgery unknown.....	1	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....
Diseases of the eye and ear.....	45	1	7	14	5	3	3	.....	2	2	6	2
Non-surgery.....	15	.....	4	1	3	2	1	.....	1	.....	1	.....
Surgery.....	19	1	.....	8	1	1	1	.....	.....	1	3	1
Surgery unknown.....	11	.....	3	1	1	.....	1	.....	.....	1	2	1



TABLE 53—*Concluded*

DIAGNOSTIC GROUP	All hos- pitals	Hos- pital A	Hos- pital B	Hos- pital C	Hos- pital D	Hos- pital E	Hos- pital F	Hos- pital G	Hos- pital H	Hos- pital I	Hos- pital J <sup>1</sup>	Hos- pital J <sup>2</sup>
Cardio-vascular diseases.....	97			45	12	9	1	2	3	4	6	3
Non-surgery.....	84	1	11	37	10	9	1	1	3	3	6	3
Surgery.....	13		1	8	2					1		
Surgery unknown.....												
Blood, splenic, lymphatic diseases.....	21		2	4	5			1	2	1	4	2
Non-surgery.....	17		2	3	5					1	3	2
Surgery.....	3							1	1	1	1	
Surgery unknown.....	1			1								
Diseases of the respiratory system.....	339	7	16	78	45	23		15	41	41	22	39
Non-surgery.....	128	4	12	63	18	5		3	2	4	10	3
Surgery.....	209	3	4	15	26	17	8	12	39	37	12	33
Surgery unknown.....	2				1	1						
Diseases of the digestive system.....	353	43	21	73	32	28	36	18	33	22	38	9
Non-surgery.....	87	9	6	22	13	2	2	9	8	9	12	3
Surgery.....	259	34	13	50	18	25	34	17	25	12	25	6
Surgery unknown.....	7		2	1	1	1				1	1	
Pertoneal and other abdominal conditions, hernias.....	76	1	6	27	5	6	12	3	3	5	5	3
Non-surgery.....	11		3	3				1			2	1
Surgery.....	59	1		23	5	5	10	2	3	4	3	1
Surgery unknown.....	6		1	1			2			1		
Diseases of the uro-genital system.....	190	10	12	40	48	12	17	5	11	17	13	5
Non-surgery.....	69	3	5	14	21	4	2	1	5	6	3	2
Surgery.....	102	7	7	17	26	8	13	3	5	10	3	3
Surgery unknown.....	19			9			2	5	2	1	3	
Diseases of skin, cellular tissue.....	67	1	6	25	15	3	2	5	6	2	1	1
Non-surgery.....	30		1	11	13	2	2	4	2	2	1	
Surgery.....	25	1	3	7	2	1		1	2			
Surgery unknown.....	12											
Non-traumatic diseases of bones and organs of movement.....	28	2	3	10	3	5	3		1	1		
Non-surgery.....	10	1	2	4	2	1	1					
Surgery.....	16	1	1	6		4				1		
Surgery unknown.....	2						1		1			
Conditions not elsewhere classified.....	26	3	3	3	7			3	4		2	1
Non-surgery.....	24	2	3	3	6			3	4		2	1
Surgery.....	1				1							
Surgery unknown.....	1	1										

<sup>1</sup> See descriptive key list of hospitals on page 219.

TABLE 54

New York State (Exclusive of New York City)

Study of Patients Discharged from Hospital Wards, 1939

2,099 HOSPITAL AND WELFARE RECORDS FROM 11 HOSPITALS SERVING  
10 REPRESENTATIVE COMMUNITIES CLASSIFIED BY DIAGNOSTIC  
GROUP BY SURGERY

DIAGNOSTIC GROUP	Total	Non-surgery	Surgery	Surgery un-known
Total.....	2,099	1,181	846	72
Infectious diseases.....	164	155	9	.....
Neoplasms.....	123	48	74	1
Rheumatic diseases, disorders of metabolism and endocrine glands, vitamin deficiencies..	93	78	15	.....
Traumatic conditions, poisonings.....	40	30	7	3
Puerperal state.....	390	349	35	6
Neurological and psychiatric conditions.....	47	46	.....	1
Diseases of the eye and ear.....	45	15	19	11
Cardio-vascular diseases.....	97	84	13	.....
Blood, splenic, lymphatic diseases.....	21	17	3	1
Diseases of the respiratory system.....	339	128	209	2
Diseases of the digestive system.....	353	87	259	7
Peritoneal and other abdominal conditions, hernias.....	76	11	59	6
Diseases of the uro-genital system.....	190	69	102	19
Diseases of skin, cellular tissue.....	67	30	25	12
Non-traumatic diseases of bones and organs of movement.....	28	10	16	2
Conditions not elsewhere classified.....	26	24	1	1

TABLE 55  
New York State (Exclusive of New York City)  
Study of Patients Discharged from Hospital Wards, 1939  
2,039 HOSPITAL RECORDS FROM 11 HOSPITALS SERVING 10 REPRESENTATIVE COMMUNITIES CLASSIFIED  
BY MORTALITY FOR DIAGNOSTIC GROUPS BY SURGERY

DIAGNOSTIC GROUP	ALL CASES			NON-SURGERY			SURGERY			SURGERY UNKNOWN		
	Total	Died	Survived	Total	Died	Survived	Total	Died	Survived	Total	Died	Survived
Total.....	2,099	168	1,931	1,181	141	1,040	846	22	824	72	5	67
Infectious diseases.....	164	33	131	155	32	123	9	1	8	.....	.....	.....
Neoplasms.....	123	23	100	48	18	30	74	4	70	.....	1	.....
Rheumatic diseases, disorders of metabolism and endocrine glands, vitamin deficiencies.....	93	7	86	78	5	73	15	2	13	.....	.....	.....
Traumatic conditions, poisonings.....	40	.....	40	30	.....	30	7	.....	7	.....	.....	.....
Puerperal state.....	390	2	388	349	.....	349	35	1	34	6	1	5
Neurological and psychiatric conditions.....	47	14	33	46	14	32	.....	.....	.....	.....	.....	.....
Diseases of the eye and ear.....	45	.....	45	15	.....	15	19	.....	19	11	.....	11
Cardio-vascular diseases.....	97	34	63	84	32	52	13	2	11	.....	.....	.....
Blood, splenic, lymphatic diseases.....	21	2	19	17	2	15	3	.....	3	.....	.....	.....
Diseases of the respiratory system.....	339	16	323	128	16	112	209	.....	209	2	.....	1
Diseases of the digestive system.....	353	15	338	87	5	82	259	10	249	7	.....	2
Peritoneal and other abdominal conditions, hernias.....	76	4	72	11	1	10	59	1	58	6	2	4
Diseases of the uro-genital system.....	190	14	176	69	12	57	102	1	101	19	1	18
Diseases of the skin, cellular tissue.....	67	2	65	30	2	28	25	.....	25	12	.....	12
Non-traumatic diseases of bones and organs of movement.....	28	.....	28	10	.....	10	16	.....	16	2	.....	2
Conditions not elsewhere classified.....	26	2	24	24	2	22	1	.....	1	1	.....	1



TABLE 56  
New York State (Exclusive of New York City)  
Study of Patients Discharged from Hospital Wards, 1939

2,099 HOSPITAL AND WELFARE RECORDS FROM 11 HOSPITALS SERVING 10 REPRESENTATIVE COMMUNITIES CLASSIFIED BY ALL SURGERY; TONSILLECTOMY AND OTHER SURGERY; OBSTETRICS, NON-SURGERY AND SURGERY UNKNOWN BY RESPONSIBILITY FOR HOSPITAL PAYMENT, INCLUDING METHOD OF PAYMENT WHEN PATIENT RESPONSIBLE, BY AREA

	(1) All hospitals		(2) Voluntary hos- pital serving rural area		(3) State aid to county hospital serving rural area		(4) City hospital serving metropolitan area		(5) Voluntary hos- pital serving metropolitan area		(6) City hospital serving a small city and surround- ing rural area	
	Number	Percent	Number	Percent	Number	Percent	Number	Percent	Number	Percent	Number	Percent
Total.....	2,099	100.0	105	100.0	155	100.0	599	100.0	304	100.0	155	100.0
Patients.....	833	39.7	65		64		56		56		103	
Cash.....	403	19.2	16		23		36		5		50	
Deferred.....	323	15.4	30		41		19		8		48	
Benefit club.....	27	1.3	13		.....		.....		5		4	
Unknown.....	80	3.8	6		.....		1		38		1	
Compensation.....	8	0.3	.....		.....		2		.....		1	
Public welfare.....	1,055	50.7	36		89		380		289		47	
Private welfare.....	14	0.7	2		.....		.....		.....		1	
Free by voluntary hospital.....	2	0.1	.....		.....		.....		.....		.....	
Other responsibility.....	162	7.7	2		2		153		.....		.....	
Unknown responsibility.....	27	1.3	.....		.....		8		9		2	
Sub Total												
ALL SURGERY.....	837	39.9	52	49.5	37	23.9	174	29.0	104	34.2	74	47.7
Patients.....	384		30		16		11		23		51	
Cash.....	197		10		5		11		.....		28	
Deferred.....	133		15		11		.....		2		22	
Benefit club.....	15		7		.....		.....		3		1	
Unknown.....	39		2		.....		.....		18		.....	
Compensation.....	3		.....		.....		1		.....		1	
Public welfare.....	380		19		21		119		80		19	
Private welfare.....	11		2		.....		.....		.....		1	
Free by voluntary hospital.....	2		.....		.....		.....		.....		.....	
Other responsibility.....	46		1		.....		42		.....		.....	
Unknown responsibility.....	5		.....		.....		1		.....		1	

TABLE 56—(Continued)

	(1)		(2)		(3)		(4)		(5)		(6)	
	Number	Percent	Number	Percent	Number	Percent	Number	Percent	Number	Percent	Number	Percent
TONSILLECTOMY.....	189	9.0			1	0.7	7	1.1	25	7.9	16	10.3
Patients.....	114		3						7		13	
Cash.....	77		1								9	
Deferred.....	11		1								3	
Benefit club.....	3		1								1	
Unknown.....	23								7			
Compensation.....												
Public welfare.....	62				1		4		16		2	
Private welfare.....	7										1	
Free by voluntary hospital.....	1											
Other responsibility.....	4						3					
Unknown responsibility.....	1								1			
OTHER SURGERY.....	648	30.9	49	46.7	36	23.2	167	27.9	80	26.3	58	37.4
Patients.....	270		27		16		11		16		38	
Cash.....	120		5		5		11				19	
Deferred.....	122		14		11				2		19	
Benefit club.....	12		6						3			
Unknown.....	16		2						11			
Compensation.....	3										1	
Public welfare.....	324		19		20		115		64		17	
Private welfare.....	4		2									
Free by voluntary hospital.....	1											
Other responsibility.....	42		1				39				1	
Unknown responsibility.....	4						1				1	

OBSTETRICS.....	352	16.8	20	19.0	26	16.8	4	10.7	52	17.1	27	17.4
Patients.....	201		17		14		6		14		24	
Cash.....	94		5		8		3		.....		10	
Deferred.....	76		7		6		2		2		12	
Benefit club.....	8		4		.....		.....		10		2	
Unknown.....	23		1		.....		1		.....		.....	
Compensation.....	.....		.....		.....		.....		38		.....	
Public welfare.....	126		3		12		37		.....		2	
Private welfare.....	1		.....		.....		.....		.....		.....	
Free by voluntary hospital.....	.....		.....		.....		.....		.....		.....	
Other responsibility.....	21		.....		.....		20		.....		.....	
Unknown responsibility.....	3		.....		.....		1		.....		1	
Non-SURGERY.....	840	40.0	32	30.5	79	50.9	339	56.6	143	47.0	52	33.8
Patients.....	226		17		30		37		17		26	
Cash.....	104		5		10		20		4		11	
Deferred.....	101		7		20		17		4		13	
Benefit club.....	4		2		.....		.....		.....		1	
Unknown.....	17		3		.....		.....		9		.....	
Compensation.....	2		.....		.....		.....		.....		.....	
Public welfare.....	505		14		47		211		119		26	
Private welfare.....	2		.....		.....		.....		.....		.....	
Free by voluntary hospital.....	.....		.....		.....		.....		.....		.....	
Other responsibility.....	88		1		.....		84		.....		.....	
Unknown responsibility.....	17		.....		2		6		7		.....	
SURGERY UNKNOWN.....	70	3.3	1	1.0	13	8.4	22	3.7	5	1.7	2	1.3
Patients.....	22		1		4		2		2		2	
Cash.....	8		.....		.....		2		1		1	
Deferred.....	13		1		4		.....		.....		.....	
Benefit club.....	.....		.....		.....		.....		.....		.....	
Unknown.....	1		.....		.....		.....		1		.....	
Compensation.....	.....		.....		.....		.....		.....		.....	
Public welfare.....	1		.....		.....		.....		.....		.....	
Private welfare.....	38		.....		9		13		2		.....	
Free by voluntary hospital.....	.....		.....		.....		.....		.....		.....	
Other responsibility.....	7		.....		.....		7		.....		.....	
Unknown responsibility.....	2		.....		.....		.....		1		.....	

<sup>1</sup> Includes 154 patient and public welfare, 2 private and public welfare, 1 private welfare and patient, 1 benefit club and patient, 1 benefit club, 1 public welfare and 2 private welfare. (See Col. 1, page 241.)





[illegible]

TABLE 56—(Concluded)

	(7)		(8)		(9)		(10)		Hospital A (11)		Hospital B (12)	
	Number	Percent	Number	Percent	Number	Percent	Number	Percent	Number	Percent	Number	Percent
NON-SURGERY.....	19	15.2	14	17.5	39	25.7	36	21.8	63	40.9	24	22.9
Patients.....	14		9		6		17		43		10	
Cash.....	9		6		.....		11		23		5	
Deferred.....	5		3		.....		6		20		4	
Benefit club.....	.....		.....		.....		.....		.....		.....	
Unknown.....	.....		.....		.....		.....		.....		.....	
Compensation.....	.....		1		.....		.....		.....		.....	
Public welfare.....	4		4		31		17		20		12	
Private welfare.....	.....		.....		.....		2		.....		.....	
Free by voluntary hospital.....	.....		.....		1		.....		.....		.....	
Other responsibility.....	1		.....		1		.....		.....		.....	
Unknown responsibility.....	.....		.....		.....		.....		.....		.....	
SURGERY UNKNOWN.....	7	5.6	3	3.7	6	4.0	3	1.8	6	3.9	2	1.9
Patients.....	4		1		1		.....		4		1	
Cash.....	1		1		.....		.....		2		.....	
Deferred.....	3		.....		1		.....		2		1	
Benefit club.....	.....		.....		.....		.....		.....		.....	
Unknown.....	.....		.....		.....		.....		.....		.....	
Compensation.....	.....		.....		.....		.....		.....		.....	
Public welfare.....	.....		.....		.....		1		.....		.....	
Private welfare.....	3		2		5		2		1		.....	
Free by voluntary hospital.....	.....		.....		.....		.....		.....		.....	
Other responsibility.....	.....		.....		.....		.....		.....		.....	
Unknown responsibility.....	.....		.....		.....		.....		.....		.....	

<sup>1</sup> Includes 154 patient and public welfare, 2 private and public welfare, 1 private welfare and patient, 1 benefit club and patient, 1 benefit club and patient, 1 benefit club, 1 public welfare and 2 private welfare. (See Col. 1, page 241.)



TABLE 57

## New York State (Exclusive of New York City)

## Study of Patients Discharged from Hospital Wards, 1939

2,099 HOSPITAL AND WELFARE RECORDS FROM 11 HOSPITALS SERVING 10 REPRESENTATIVE COMMUNITIES CLASSIFIED BY ALL SURGERY, TONSILLECTOMY AND OTHER SURGERY, OBSTETRICS, NON-SURGERY, AND SURGERY UNKNOWN BY RESPONSIBILITY FOR PAYMENT OF HOSPITAL CHARGES, INCLUDING METHOD OF PAYMENT WHEN PATIENT WAS RESPONSIBLE

RESPONSIBILITY FOR HOSPITAL CHARGES	Total	SURGERY			Obstet- rics <sup>2</sup>	Non- surgery	Surgery unknown
		Sub- total: all surgery	Tonsil- lectomy <sup>1</sup>	Other surgery			
Total.....	2,099	837	189	648	352	839	71
Not reported <sup>3</sup> .....	27	5	1	4	3	17	2
Reported.....	2,072	832	188	644	349	822	69
Patient responsibility.....	833	384	114	270	201	226	22
Cash.....	403	197	77	120	94	104	8
Deferred payment.....	323	133	11	122	76	101	13
Benefit club.....	27	15	3	12	8	4	.....
Unknown method of pay- ment.....	80	39	23	16	23	17	1
Public welfare responsibility..	1,055	386	62	324	126	504	39
Mixed responsibility.....	160	46	4	42	21	86	7
All other responsibility.....	24	16	8	8	1	6	1

<sup>1</sup> Excludes 4 patients admitted for tonsillectomy but not operated.

<sup>2</sup> Includes 9 surgery and 1 surgery unknown. Abortions not included in this group.

<sup>3</sup> As to responsibility for payment of hospital charges.

TABLE 58

## New York State (Exclusive of New York City)

## Study of Patients Discharged from Hospital Wards, 1939

2,099 HOSPITAL AND WELFARE RECORDS FROM 11 HOSPITALS<sup>1</sup> SERVING 10 REPRESENTATIVE COMMUNITIES CLASSIFIED BY PHYSICIAN TREATING PATIENT IN HOSPITAL

PHYSICIAN TREATING PATIENT IN HOSPITAL	All hospitals	Hospital A	Hospital B	Hospital C	Hospital D	Hospital E	Hospital F	Hospital G	Hospital H	Hospital I	Hospital J <sub>1</sub>	Hospital J <sub>2</sub>
Total.....	2,099	105	155	599	304	155	125	80	152	165	154	105
Not reported.....	12	.....	2	.....	.....	.....	.....	.....	.....	.....	8	2
Reported.....	2,087	105	153	599	304	155	125	80	152	165	146	103
Referring physician.....	2,604	53	21	.....	.....	123	108	65	2	140	78	14
Staff physician at hospital.....	1,438	42	132	599	304	23	13	14	149	15	60	87
Both referring and staff physicians.....	45	10	.....	.....	.....	9	4	1	1	10	8	2

<sup>1</sup> See descriptive key list of hospitals on page 219.

TABLE 59  
New York State (Exclusive of New York City)  
Study of Patients Discharged from Hospital Wards, 1939

2,099 HOSPITAL AND WELFARE RECORDS FROM 11 HOSPITALS<sup>1</sup> SERVING 10 REPRESENTATIVE COMMUNITIES CLASSIFIED BY RESPONSIBILITY FOR PAYMENT OF HOSPITAL CHARGES, INCLUDING METHOD OF PAYMENT WHEN PATIENT WAS RESPONSIBLE, BY HOSPITAL<sup>1</sup>

RESPONSIBILITY FOR HOSPITAL CHARGES	All hospitals	Percent	Hospital A	Hospital B	Hospital C	Hospital D	Hospital E	Hospital F	Hospital G	Hospital H	Hospital I	Hospital J <sup>1</sup>	Hospital J <sup>2</sup>
Total.....	2,099	.....	105	155	599	304	155	125	80	152	165	154	105
Not reported.....	27	.....	.....	2	8	9	2	1	.....	3	.....	2	.....
Reported.....	2,072	100.0	105	153	591	295	153	124	80	149	165	152	105
Patient responsibility.....	833	40.2	65	64	56	56	103	98	53	58	111	108	61
Cash.....	403	19.4	16	23	36	5	50	59	35	16	80	48	35
Deferred payment.....	323	15.6	30	41	19	8	48	38	15	10	31	59	24
Benefit club.....	27	1.3	13	.....	.....	5	4	.....	3	.....	.....	.....	2
Unknown method of payment.....	80	3.9	6	.....	1	38	1	1	.....	32	.....	1	.....
Public welfare responsibility.....	1,055	50.9	36	89	380	239	47	26	25	85	44	44	40
Mixed responsibility.....	160	7.7	.....	.....	153	.....	41	.....	.....	3	.....	.....	6
All other responsibility.....	24	1.2	.....	.....	2	.....	2	.....	10	3	13	.....	3

<sup>1</sup> See descriptive key list of hospitals on page 219.

<sup>2</sup> Two patient (1 through benefit club) plus public welfare.

<sup>3</sup> Includes 152 patient plus public welfare (city hospital arranges part pay) and 1 public welfare plus private welfare.

<sup>4</sup> Patient plus public welfare.

<sup>5</sup> Includes patient plus public welfare.

<sup>6</sup> Patient plus private welfare.

<sup>7</sup> Private welfare.

<sup>8</sup> Workmen's compensation.

<sup>9</sup> Includes 1 private welfare and 1 workmen's compensation.

<sup>10</sup> Includes 1 hospital and 1 workmen's compensation.

<sup>11</sup> Includes 2 private welfare and 1 hospital.

<sup>12</sup> Includes 8 private welfare and 2 workmen's compensation.

<sup>13</sup> Includes 1 private welfare and 2 not charged (admitted for tonsillectomy and not operated due to slow clotting time).





Rheumatic diseases, disorders of metabolism and endocrine glands, vitamin deficiencies.....	93	38	55	3	2	3	1	6	3	5	13	18	15	11	13	7	86
Rheumatic diseases.....	20	15	11	.....	.....	.....	1	2	2	.....	4	6	3	5	1	.....	20
Diabetes mellitus, uncomplicated.....	32	17	.....	.....	.....	1	.....	2	2	3	5	2	5	5	9	1	31
Diabetes mellitus, complicated.....	14	4	10	.....	.....	.....	.....	1	1	.....	2	1	1	5	3	3	11
All other metabolic conditions, including malnutrition.....	6	5	1	3	.....	1	1	1	.....	1	.....	.....	.....	.....	.....	1	5
Disorders of the thyroid gland.....	17	3	14	.....	.....	1	.....	.....	.....	.....	2	8	6	.....	.....	2	15
All other endocrine conditions.....	2	1	1	.....	2	.....	.....	.....	.....	1	.....	1	.....	.....	.....	.....	2
Vitamin deficiencies.....	2	1	1	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	2
Traumatic conditions, poisonings.....	40	24	16	2	2	1	6	3	5	1	5	3	3	5	4	.....	40
Traumatic fractures.....	11	8	3	.....	.....	.....	.....	1	1	1	2	1	1	2	2	.....	40
All other traumatic conditions.....	23	13	10	2	1	1	6	2	2	3	3	2	1	2	1	.....	23
Poisonings, including alcoholism.....	6	3	3	.....	1	.....	.....	.....	2	.....	.....	.....	1	1	1	.....	6
Puerperal state.....	390	.....	390	.....	.....	.....	.....	.....	49	135	165	37	4	.....	.....	2	388
Pregnancy without indication of obstetrical complication, delivered.....	316	.....	316	.....	.....	.....	.....	.....	43	115	126	30	2	.....	.....	.....	316
Pregnancy with obstetrical complications, delivered.....	27	.....	27	.....	.....	.....	.....	.....	2	10	12	2	1	.....	.....	2	25
Abortion.....	38	.....	38	.....	.....	.....	.....	.....	4	8	20	5	1	.....	.....	.....	38
Pregnancy, outcome unknown, including untermated pregnancies.....	9	.....	1	.....	.....	.....	.....	.....	.....	2	7	.....	.....	.....	.....	.....	9
Neurological and psychiatric conditions.....	47	19	28	2	.....	.....	1	3	.....	1	4	5	7	10	14	14	33
Vascular cerebral accident.....	26	7	19	.....	.....	.....	.....	.....	.....	.....	.....	2	4	8	12	12	14
All other conditions of the nervous system in general.....	10	5	5	2	.....	.....	1	1	.....	1	2	3	2	1	1	2	8
Psychiatric conditions.....	11	7	4	.....	.....	.....	.....	2	.....	.....	.....	.....	.....	.....	.....	.....	11
Diseases of the eye and ear.....	45	24	21	4	4	2	3	7	1	3	3	4	3	5	6	.....	45
Cataract and glaucoma.....	10	7	3	.....	.....	.....	.....	1	.....	.....	.....	.....	2	3	4	.....	10
All other diseases of the ophthalmic system.....	12	.....	.....	.....	.....	.....	.....	3	.....	1	1	3	1	2	.....	.....	2
Mastoiditis and otitis media, acute.....	14	7	7	3	2	1	2	2	1	1	2	1	.....	.....	2	.....	14
Mastoiditis and otitis media, chronic.....	9	3	6	.....	2	1	1	1	.....	1	.....	.....	.....	.....	.....	.....	9
All other diseases of the auditory system.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....
Cardio-vascular diseases.....	97	60	37	1	.....	.....	1	1	.....	1	5	6	20	24	38	34	63
Cardiac diseases.....	52	31	21	1	.....	.....	1	.....	.....	1	2	3	11	11	22	22	30
General arteriosclerosis.....	22	16	6	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	6	15	10	12
Other arterial diseases.....	7	4	3	.....	.....	.....	.....	.....	.....	.....	1	1	2	3	.....	1	6
Varices.....	14	9	5	.....	.....	.....	.....	.....	.....	.....	2	2	5	4	1	.....	14
All other venous and capillary diseases.....	2	.....	2	.....	.....	.....	.....	.....	.....	1	1	.....	1	.....	.....	1	1
Blood, splenic, lymphatic diseases.....	21	10	11	2	2	1	1	4	1	.....	.....	.....	6	3	1	2	19
Periculous anemia.....	5	2	3	.....	.....	.....	.....	.....	.....	.....	.....	.....	3	1	1	.....	5
All other diseases of the hemic system.....	5	2	3	1	.....	.....	.....	1	.....	.....	.....	.....	1	2	.....	2	3
Acute lymphadenitis, abscess of lymph-nodes.....	9	4	5	1	2	1	1	3	.....	.....	.....	.....	1	.....	.....	.....	9
All other diseases of the lymphatic system.....	2	2	.....	.....	.....	.....	.....	.....	1	.....	.....	.....	1	.....	.....	.....	2

TABLE 60—(Continued)

DIAGNOSIS	Total cases	Sex		Age										MORTALITY			
		Male	Fe- male	Under 1 year 2 years	1 year and less than 2 years	2 years and less than 5 years	5 years and less than 10 years	10 years and less than 15 years	15 years and less than 20 years	20 years and less than 25 years	25 years and less than 35 years	35 years and less than 45 years	45 years and less than 55 years	55 years and less than 65 years	65 years and over	Died	Sur- vived
Diseases of the respiratory system . . . . .	339	200	139	8	7	44	107	45	15	17	22	34	15	11	14	16	323
Infectious hypertrophy of tonsil, adenoid . . . . .	1193	97	96	.....	3	25	97	35	13	7	6	5	2	.....	.....	.....	193
Sinusitis . . . . .	4	3	1	.....	.....	.....	1	.....	.....	.....	1	1	.....	.....	.....	.....	4
Other diseases of the upper respiratory tract . . . . .	48	34	14	3	3	5	6	5	1	5	9	8	1	1	1	2	46
Broncho-pneumonia . . . . .	11	8	3	2	.....	3	.....	1	.....	1	.....	1	.....	.....	.....	2	9
Lobar pneumonia . . . . .	43	30	13	1	.....	9	1	3	1	2	4	10	8	2	2	8	35
Pneumonia, unspecified . . . . .	4	3	1	.....	.....	.....	.....	1	.....	.....	.....	.....	1	.....	1	.....	4
All other forms of pneumonia . . . . .	3	3	.....	.....	.....	.....	.....	.....	.....	.....	1	.....	.....	.....	.....	2	3
Chronic bronchitis . . . . .	9	7	2	1	.....	.....	1	.....	.....	1	.....	1	1	1	4	1	8
Bronchial asthma . . . . .	10	5	5	.....	1	2	1	.....	.....	.....	.....	2	.....	.....	1	.....	10
Pleural conditions . . . . .	3	3	.....	.....	.....	.....	.....	.....	.....	.....	.....	1	.....	.....	.....	.....	3
All other diseases of the lower respiratory tract . . . . .	11	7	4	.....	.....	.....	.....	.....	.....	1	1	1	2	4	2	1	10
Diseases of the digestive system . . . . .	353	171	182	4	6	11	18	40	65	40	49	35	41	24	20	15	338
Diseases of teeth and gums . . . . .	12	6	6	.....	1	.....	.....	1	5	1	1	3	.....	.....	.....	.....	12
Other diseases of mouth and pharynx . . . . .	15	5	.....	.....	.....	1	.....	1	1	.....	.....	1	.....	.....	.....	.....	5
Ulcer of stomach and duodenum . . . . .	18	17	1	.....	.....	.....	.....	.....	.....	.....	4	3	6	2	3	2	16
Gastro-enteritis, colitis, colitis ulcerosa . . . . .	37	18	19	3	5	5	7	1	3	5	.....	3	4	4	1	4	37
Appendicitis, acute . . . . .	142	70	72	.....	.....	.....	8	30	37	21	20	12	4	4	1	4	138
Appendicitis, chronic . . . . .	32	7	25	.....	.....	.....	1	1	9	7	8	2	2	2	.....	.....	32
Appendicitis, unknown . . . . .	14	5	9	.....	.....	.....	2	3	4	1	9	5	8	5	.....	1	13
Hemorrhoids . . . . .	28	19	9	.....	.....	.....	.....	.....	.....	.....	.....	2	3	1	.....	.....	28
All other diseases of rectum and anus . . . . .	14	10	4	.....	.....	.....	.....	2	2	2	.....	2	2	3	2	.....	14
All other diseases of the gastro-intestinal tract and pancreas . . . . .	13	3	10	1	.....	.....	.....	.....	2	.....	.....	2	2	.....	6	1	12
Cirrhosis of liver . . . . .	3	1	2	.....	.....	.....	.....	1	.....	1	.....	.....	1	.....	.....	2	2
Other liver diseases . . . . .	2	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	2
Diseases of the bile passages . . . . .	33	8	25	.....	.....	.....	.....	.....	2	.....	3	1	9	10	6	5	28



Peritoneal and other abdominal conditions, hernias.....	76	56	20	...	2	1	1	1	4	5	14	14	16	5	13	4	72
Peritoneal adhesions.....	7	1	6	...	...	...	...	...	...	1	3	1	...	...	2	1	6
Other conditions of the abdominal cavity.....	9	7	2	...	1	1	1	...	4	1	...	1	1	1	3	2	7
Hernia.....	60	48	12	...	1	...	...	...	...	3	11	12	15	4	8	1	59
Diseases of the uro-genital system.....	190	68	122	2	...	2	2	4	10	12	38	35	35	16	27	14	176
Diseases of the kidney parenchyma.....	13	4	9	1	...	...	...	...	1	...	1	3	3	3	2	8	5
Calculus in the urinary system.....	14	9	5	...	...	...	...	...	...	1	2	4	4	1	2	...	14
Other diseases of the urinary system.....	32	15	17	...	1	1	1	...	...	4	8	5	9	3	1	...	32
Benign hypertrophy of prostate.....	26	26	...	...	...	...	...	...	...	...	...	...	2	6	18	5	21
All other diseases of the male genital system.....	7	7	...	...	...	...	2	...	...	...	...	1	1	2	1	...	7
Phimosis.....	7	7	...	1	...	2	1	...	1	...	...	1	1	...	...	...	7
Salpingitis, oophoritis, acute.....	9	...	9	...	...	...	...	...	2	2	3	1	1	...	...	...	9
Salpingitis, oophoritis, chronic.....	20	...	20	...	...	...	...	3	3	4	7	4	2	...	...	...	9
Salpingitis, oophoritis, unknown.....	3	...	3	...	...	...	...	...	1	1	1	1	...	...	...	...	20
Diseases of uterus and cervix.....	23	...	23	...	...	...	...	...	...	1	9	6	6	1	...	1	3
Displacement of uterus, rectocele, cystocele.....	15	...	15	...	...	...	...	...	...	2	2	4	5	...	2	...	15
Vulvitis, vaginitis.....	7	...	7	...	...	...	...	...	1	1	2	1	2	...	...	...	7
All other non-puerperal diseases of the female genital system.....	11	...	11	...	...	...	...	...	2	3	2	3	1	...	...	...	11
Non-puerperal diseases of female breast.....	3	...	3	...	...	...	...	...	...	...	...	2	...	...	1	...	3
Diseases of skin, cellular tissue.....	67	39	28	3	...	6	7	6	3	6	5	6	12	5	8	2	65
Furuncle, furunculosis, carbunculus, cellulitis, superficial ulcer.....	45	28	17	1	...	4	2	3	3	5	4	5	8	3	7	2	43
Other infections and infestations of skin.....	10	5	5	...	1	1	5	...	...	1	1	1	1	...	...	...	10
All other diseases of skin.....	12	6	6	2	...	1	...	3	...	...	...	...	3	2	1	...	12
Non-traumatic diseases of bones and organs of movement.....	28	16	12	1	...	1	1	4	1	2	3	6	6	...	3	...	28
Osteomyelitis.....	8	4	4	1	...	...	1	1	...	1	1	...	3	...	...	...	8
Other infections of the musculo-skeletal system.....	1	1	...	...	...	...	...	...	...	...	...	...	...	...	...	...	1
Orthopedic defect for correction.....	14	9	5	...	...	1	...	2	1	1	1	4	2	...	2	...	14
All other conditions of the musculo-skeletal system.....	5	2	3	...	...	...	1	1	...	...	1	2	...	...	1	...	5
Conditions not elsewhere classified.....	26	15	11	3	...	1	1	1	3	1	5	6	3	1	1	2	24
For diagnosis only.....	3	...	3	...	...	...	...	...	...	...	...	...	1	1	...	...	3
Undiagnosed conditions.....	16	10	6	1	...	1	1	1	1	1	3	5	1	1	1	2	14
Not stated.....	4	3	1	...	...	...	...	...	2	...	...	1	1	...	...	...	4
Not ill.....	3	2	1	2	...	...	...	...	...	...	...	...	...	...	...	...	3

1 Includes 4 not operated.



Rheumatic diseases, disorders of metabolism and endocrine glands, vitamin deficiencies	95	1	5	13	26	13	13	10	2	1	2	2
Rheumatic diseases.....	20	.....	2	4	2	2	4	.....	1	.....	.....	.....
Diabetes mellitus, uncomplicated.....	32	.....	.....	6	12	3	7	3	1	.....	.....	.....
Diabetes mellitus, complicated.....	14	.....	2	2	3	2	1	1	.....	.....	.....	.....
All other metabolic conditions, including malnutrition.....	6	.....	1	.....	2	1	.....	2	.....	.....	.....	.....
Disorders of the thyroid gland.....	17	.....	.....	.....	4	5	1	4	1	.....	.....	.....
All other endocrine conditions.....	2	.....	.....	1	1	.....	.....	.....	.....	.....	.....	.....
Vitamin deficiencies.....	2	.....	.....	.....	2	.....	.....	.....	.....	.....	.....	.....
Traumatic conditions, poisoning.....	40	.....	5	11	8	8	1	2	2	.....	.....	.....
Traumatic fracture.....	11	.....	1	4	.....	4	1	1	1	.....	.....	.....
All other traumatic conditions.....	23	.....	3	6	7	2	1	1	1	.....	.....	.....
Poisonings, including alcoholism.....	6	.....	1	1	1	2	.....	.....	.....	.....	.....	.....
Puerperal state.....	390	.....	6	52	300	24	3	2	1	.....	.....	.....
Pregnancy without indication of obstetrical complication, delivered.....	316	.....	2	30	266	15	2	1	.....	.....	.....	.....
Pregnancy with obstetrical complications, delivered.....	37	.....	.....	4	11	8	1	.....	1	.....	.....	.....
Abortion.....	38	.....	2	15	19	1	.....	1	.....	.....	.....	.....
Pregnancy, outcome unknown, including untermiated pregnancies.....	9	.....	2	3	4	.....	.....	.....	.....	.....	.....	.....
Neurological and psychiatric conditions.....	47	1	6	10	6	9	5	2	1	.....	.....	2
Vascular cerebral accident.....	26	1	3	4	4	3	2	2	1	.....	.....	1
All other conditions of the nervous system in general.....	10	.....	2	2	1	2	2	.....	.....	.....	.....	.....
Psychiatric conditions.....	11	.....	1	4	1	4	1	.....	.....	.....	.....	.....
Diseases of the eye and ear.....	45	.....	4	12	16	6	3	2	1	.....	.....	1
Cataract and glaucoma.....	10	.....	1	1	4	3	.....	.....	1	.....	.....	.....
All other diseases of the ophthalmic system	12	.....	4	4	3	2	1	2	.....	.....	.....	.....
Mastoiditis and otitis media, acute.....	14	.....	2	5	7	.....	.....	.....	.....	.....	.....	.....
Mastoiditis and otitis media, chronic.....	9	.....	1	2	2	1	2	.....	.....	.....	.....	1
All other diseases of the auditory system.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....
Cardio-vascular diseases.....	97	3	11	16	23	19	9	4	2	2	3	3
Cardiac diseases.....	52	3	6	6	11	11	5	2	1	1	.....	.....
General arteriosclerosis.....	22	.....	2	5	4	3	3	2	.....	.....	.....	.....
Other arterial diseases.....	27	.....	1	1	2	2	1	.....	.....	.....	.....	.....
Varices.....	14	.....	1	4	5	3	.....	.....	.....	1	.....	.....
All other venous and capillary diseases.....	2	.....	1	.....	1	.....	.....	.....	.....	.....	.....	.....
Blood, splenic lymphatic diseases.....	21	.....	4	3	6	5	1	1	1	.....	.....	.....
Pernicious anemia.....	5	.....	.....	.....	1	1	2	.....	.....	.....	.....	.....
All other diseases of the hemic system.....	5	.....	.....	1	1	1	.....	.....	.....	.....	.....	.....
Acute lymphadenitis, abscess of lymph-nodes	9	.....	3	2	3	1	.....	.....	.....	.....	.....	.....
All other diseases of the lymphatic system.....	2	.....	.....	.....	1	1	.....	.....	.....	.....	.....	.....



TABLE 61—Continued

	Total (1)	LENGTH OF STAY IN HOSPITAL										
		Less than 1 day (2)	1 day and less than 3 days (3)	3 days and less than 1 week (4)	1 week and less than 2 weeks (5)	2 weeks and less than 3 weeks (6)	3 weeks and less than 4 weeks (7)	4 weeks and less than 5 weeks (8)	5 weeks and less than 6 weeks (8)	6 weeks and less than 7 weeks (10)	7 weeks and less than 8 weeks (11)	8 weeks and less than 12 weeks (12)
Diseases of the respiratory system.....	339	25	171	50	44	21	12	7	3	1	1	3
Infectious hypertrophy of tonsil, adenoid.....	4 193	22	156	15	1	.....	.....	.....	.....	.....	.....	.....
Sinusitis.....	4	.....	1	2	.....	.....	.....	.....	.....	.....	.....	.....
Other diseases of the upper respiratory tract.....	48	1	11	19	9	5	1	1	.....	.....	.....	1
Broncho-pneumonia.....	11	1	.....	1	4	2	6	1	1	.....	1	1
Lobar pneumonia.....	43	1	2	5	18	7	.....	2	1	.....	.....	.....
Pneumonia, unspecified.....	4	.....	.....	.....	3	1	.....	.....	.....	.....	.....	.....
All other forms of pneumonia.....	3	.....	.....	.....	1	.....	3	1	.....	.....	.....	.....
Chronic bronchitis.....	9	.....	.....	.....	1	.....	.....	.....	.....	.....	.....	.....
Bronchial asthma.....	10	.....	.....	6	4	.....	.....	.....	.....	.....	.....	.....
Pleural conditions.....	3	.....	.....	2	.....	1	.....	.....	.....	.....	.....	.....
All other diseases of the lower respiratory tract.....	11	.....	1	.....	3	2	2	2	.....	.....	.....	1
Diseases of the digestive system.....	353	1	27	43	157	70	21	11	10	2	3	6
Diseases of the teeth and gums.....	12	.....	3	3	2	1	.....	.....	.....	1	.....	.....
Other diseases of mouth and pharynx.....	15	.....	.....	3	3	1	.....	.....	.....	.....	.....	.....
Ulcer of stomach and duodenum.....	2 18	1	.....	2	2	1	1	2	1	.....	.....	2
Gastro-enteritis, colitis, colitis ulcerosa.....	37	.....	11	11	4	2	3	3	2	.....	1	1
Appendicitis, acute.....	142	.....	3	4	94	30	6	.....	4	.....	.....	.....
Appendicitis, chronic.....	32	.....	.....	.....	20	7	1	.....	.....	.....	.....	.....
Appendicitis, unknown.....	14	.....	3	.....	5	3	.....	.....	1	.....	.....	.....
Hemorrhoids.....	28	.....	.....	5	17	7	.....	.....	.....	.....	.....	.....
All other diseases of rectum and anus.....	14	.....	3	5	2	4	.....	.....	.....	1	.....	.....
All other diseases of the gastro-intestinal tract and pancreas.....	13	.....	1	2	4	2	2	1	.....	.....	.....	1
Cirrhosis of liver.....	3	.....	1	1	.....	.....	.....	.....	.....	.....	.....	1
Other liver diseases.....	2	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....
Other diseases of the bile passages.....	33	.....	2	4	6	7	4	5	2	.....	2	.....
Peritoneal and other abdominal conditions, hernias.....	76	1	3	10	16	26	11	2	1	.....	1	3
Peritoneal adhesions.....	7	.....	.....	4	1	1	.....	.....	.....	.....	.....	1
Other conditions of the abdominal cavity.....	2 9	.....	1	1	4	.....	1	.....	.....	.....	.....	.....
Hernia.....	2 60	1	2	5	11	25	10	2	1	.....	1	.....

Diseases of the uro-genital system. ....	190	3	22	38	40	33	20	12	7	5	2	7
Diseases of the kidney parenchyma. ....	13	2	1	3	3	2	2	1	1	1	1	1
Calculus in the urinary system. ....	14	1	7	4	7	1	1	3	1	1	1	1
Other diseases of the urinary system. ....	32	1	2	12	8	4	2	1	3	2	1	3
Benign hypertrophy of prostate. ....	26	1	2	1	1	3	1	1	1	1	1	1
All other diseases of the male genital system	7	1	3	3	1	1	1	1	1	1	1	1
Phimosis. ....	7	1	3	3	1	1	1	1	1	1	1	1
Salpingitis, oöphoritis, acute. ....	9	1	2	2	1	2	1	2	1	1	1	2
Salpingitis, oöphoritis, chronic. ....	20	1	1	2	6	3	3	2	1	1	1	1
Salpingitis, oöphoritis, unknown. ....	3	1	1	2	2	1	1	2	1	1	1	1
Diseases of uterus and cervix. ....	23	1	3	4	5	8	1	2	1	1	1	1
Displacement of uterus, rectocele	15	1	3	4	4	4	6	1	1	1	1	1
Displacement of uterus, cystocele	15	1	3	4	4	4	6	1	1	1	1	1
Vulvitis, vaginitis. ....	7	1	2	3	1	1	1	1	1	1	1	1
All other non-puerperal diseases of the	11	1	2	3	1	3	2	1	1	1	1	1
female genital system. ....	3	1	1	2	2	3	2	1	1	1	1	1
Non-puerperal diseases of female breast. ....	3	1	1	2	2	3	2	1	1	1	1	1
Diseases of skin, cellular tissue. ....	67	1	7	17	19	7	9	3	1	1	1	3
Furuncle, furunculosis, carbunculus, cellulitis, superficial ulcer. ....	45	1	6	10	15	5	6	1	1	1	1	1
Other infections and infestations of skin. ....	10	1	1	2	2	2	2	1	1	1	1	1
All other diseases of skin. ....	12	1	1	5	2	2	1	1	1	1	1	1
Non-traumatic diseases of bones and organs of movement. ....	28	1	4	6	6	5	1	1	1	1	1	2
Osteomyelitis. ....	8	1	1	2	1	1	1	1	1	1	1	1
Other infections of the musculo-skeletal system. ....	1	1	1	2	4	3	1	1	1	1	1	1
Orthopedic defect for correction. ....	14	1	2	2	4	3	1	1	1	1	1	1
All other conditions of the musculo-skeletal system. ....	5	1	2	2	1	1	1	1	1	1	1	1
Conditions not elsewhere classified	26	2	4	8	3	6	1	1	1	1	1	1
For diagnosis only. ....	3	1	1	1	1	1	1	1	1	1	1	1
Undiagnosed conditions. ....	16	1	3	7	1	3	1	1	1	1	1	1
Not stated. ....	4	1	1	1	1	2	1	1	1	1	1	1
Not ill. ....	3	1	1	1	2	1	1	1	1	1	1	1

1 Includes 6 cases for which length of stay in hospital was not reported.

2 Includes 154 patient and public welfare, 2 private and public welfare, 1 private welfare and patient, 1 benefit club and patient, 1 benefit club, 1 public welfare and 2 private welfare.

3 Includes 1 case for which length of stay in hospital was not reported.

4 Includes 4 not operated.





Traumatic conditions, poisoning.	1	15	22	3	3
Traumatic fractures.		6	5		
All other traumatic conditions.	1	8	13	2	
Poisonings, including alcoholism.		1	4	1	
Puerperal state.	1	219	143	23	3
Pregnancy without indication of obstetrical complication, delivered.				2	
Pregnancy with obstetrical complications, delivered.				1	3
Abortion.	1	15	7		5
Pregnancy, outcome unknown, including untermiated pregnancies.		18	17	1	2
Neurological and psychiatric conditions.		1	8		
Vascular cerebral accident.	1	10	31		6
All other conditions of the nervous system in general.	1	6	17		3
Psychiatric conditions.		3	6	1	1
Psychiatric conditions.		1	8	2	
Diseases of the eye and ear.		11	30	4	
Cataract and glaucoma.		1	9		
All other diseases of the ophthalmic system.		3	8		1
Mastoiditis and otitis media, acute.		4	9	1	2
Mastoiditis and otitis media, chronic.		3	4	2	
All other diseases of the auditory system.					
Cardio-vascular diseases.	2	24	58	13	2
Cardiac diseases.	1	15	31	4	2
General arteriosclerosis.	1	3	12	7	
Other arterial diseases.		3	4		
Varices.		2	10	2	
All other venous and capillary diseases.		1	1		
Blood, splenic, lymphatic diseases.		8	11	2	
Pernicious anemia.	1	1	3	1	
All other diseases of the hemic system.	1	1	3	1	
Acute lymphadenitis, abscess of lymph-nodes.		4	5		
All other diseases of the lymphatic system.		2			
Diseases of the respiratory system.	1	156	148	21	5
Infectious hypertrophy of tonsil, adenoid.		116	62	6	1
Sinusitis.		1	3		
Other diseases of the upper respiratory tract.		16	26	4	2
Broncho-pneumonia.		3	6	1	1
Lobar pneumonia.		10	24	7	1
Pneumonia, unspecified.		1	3		
All other forms of pneumonia.		2	1		
Chronic bronchitis.	1	2	7	2	
Bronchial asthma.		4	6		
Pleural conditions.		2	1		
All other diseases of the lower respiratory tract.		1	9	1	



	14	1	44	6	2
Diseases of skin, cellular tissue					
Furuncle, furunculosis, carbunculus, cellulitis, abscess, pyoderma	12	1	28	3	1
Other infections and infestations of skin	1		8	1	
All other diseases of skin	1		8	1	
Non-traumatic diseases of bones and organs of movement					
Osteomyelitis	8	1	16	3	
Other infections of the musculo-skeletal system	5		2	1	
Orthopedic defect for correction	1				
All other conditions of the musculo-skeletal system	2	1	10	1	
Conditions not elsewhere classified or diagnosis only			4	1	
Undiagnosed conditions	10		16		
Not stated	1		2		
Not ill	1		2		

<sup>1</sup> Includes 6 cases for which length of stay in hospital was not reported.

\* Includes 154 patient and public welfare, 2 private and public welfare, 1 private welfare and patient, 1 benefit club and patient, 1 benefit club, 1 public welfare and 2 private welfare.

Includes 1 case for private welfare.

<sup>1</sup> Includes 1 case for which length of stay in hospital was not reported.  
<sup>4</sup> Includes 4 not operated.



TABLE 62

New York State (Exclusive of New York City)

Study of Patients Discharged from Hospital Wards, 1939

1,008 HOSPITAL RECORDS FROM 3 HOSPITALS CLASSIFIED BY SOURCE OF REFERRAL TO HOSPITAL AND FOLLOW-UP ADVISED BY HOSPITAL BY HOSPITAL<sup>1</sup>

	All hospitals	Hospital C	Hospital D	Hospital J <sub>1</sub>
All patients.....	1,008	599	304	105
Died in hospital.....	106	96	3	7
Surviving patients.....	902	503	301	98
Patients for whom referral to hospital was <i>not</i> reported.....	120	53	63	4
Surviving patients for whom referral to hospital <i>was</i> reported.....	782	450	238	94
Patients referred by physician.....	366	172	106	88
Referred for follow-up to physician.....	93	74	17	2
Referred for follow-up to clinic....	172	83	76	13
Transferred to other institution....	1	1	.....	.....
No follow-up referral noted.....	100	14	13	73
Patients referred by clinic.....	336	210	120	6
Referred for follow-up to physician.....	2	1	1	.....
Referred for follow-up to clinic....	317	202	113	2
Transferred to other institution....	2	2	.....	.....
No follow-up referral noted.....	15	5	6	4
Patients transferred from other hospital.....	18	10	8	.....
Referred for follow-up to physician.....	.....	.....	.....	.....
Referred for follow-up to clinic....	8	4	4	.....
Transferred to other institution....	2	1	1	.....
No follow-up referral noted.....	8	5	3	.....
Patients referred to city physician....	62	58	4	.....
Referred for follow-up to clinic....	58	54	4	.....
No follow-up referral noted.....	4	4	.....	.....

<sup>1</sup>See descriptive key list of hospitals on page 219.

TABLE 63

New York State (Exclusive of New York City)

Study of Patients Discharged from Hospital Wards, 1939

630 WARD PATIENTS (OBSTETRICAL PATIENTS EXCLUDED) CLASSIFIED BY INTERVALS BETWEEN FIRST SYMPTOM AND HOSPITAL ADMISSION

TIME INTERVAL	First symptom and medical attention	First medical attention and hospital admission	First symptom and hospital admission
Total.....	630	630	630
Not reported.....	17	11	13
Reported.....	613	619	617
Total under 1 month.....	424	328	240
Under 1 month, unspecified.....	154	86	10
Under 1 day.....	134	116	56
1 day and under 2 days.....	42	38	42
2 days and under 3 days.....	23	17	22
3 days and under 4 days.....	20	12	17
4 days and under 1 week.....	15	11	23
1 week and under 2 weeks.....	26	28	41
2 weeks and under 3 weeks.....	9	13	21
3 weeks and under 1 month.....	1	7	8
1 month and under 2 months.....	21	43	32
2 months and under 3 months.....	11	24	19
3 months and under 6 months.....	19	51	52
6 months and under 9 months.....	12	25	36
9 months and under 1 year.....	5	18	17
1 year and under 2 years.....	35	41	51
2 years and under 5 years.....	44	59	102
5 years and under 10 years.....	11	17	24
10 years and under 15 years.....	18	5	22
15 years and under 20 years.....	7	4	10
20 years and over.....	6	4	12

TABLE 64

New York State (Exclusive of New York City)

Study of Patients Discharged from Hospital Wards, 1939

630 WARD PATIENTS (OBSTETRICAL PATIENTS EXCLUDED) CLASSIFIED BY INTERVAL BETWEEN FIRST SYMPTOM AND FIRST MEDICAL ATTENTION<sup>1</sup>

TIME INTERVAL	All hospitals	Hospital A	Hospital D	Hospital F	Hospital H	Hospital J <sub>1</sub>	Hospital J <sub>2</sub>
Total.....	630	76	192	85	94	108	75
Not reported.....	17	.....	10	2	4	1	.....
Reported.....	613	76	182	83	90	107	75
Total under 1 month.....	424	58	122	54	53	84	53
Under 1 month, unspecified.....	154	8	39	20	22	25	40
Under 1 day.....	134	25	27	18	17	38	9
1 day and under 2 days.....	42	12	17	4	5	3	1
2 days and under 3 days.....	23	2	4	4	5	7	1
3 days and under 4 days.....	20	5	10	3	.....	2	.....
4 days and under 1 week.....	15	2	8	1	3	1	.....
1 week and under 2 weeks.....	26	1	12	4	.....	7	2
2 weeks and under 3 weeks.....	9	2	5	.....	1	1	.....
3 weeks and under 1 month.....	1	1	.....	.....	.....	.....	.....
1 month and under 2 months....	21	3	6	2	3	4	3
2 months and under 3 months....	11	1	3	2	3	1	1
3 months and under 6 months....	19	4	1	3	2	5	4
6 months and under 9 months....	12	1	3	1	2	4	1
9 months and under 1 year.....	5	.....	2	3	.....	.....	.....
1 year and under 2 years.....	35	2	15	5	5	3	5
2 years and under 5 years.....	44	3	18	6	11	3	3
5 years and under 10 years.....	11	.....	4	.....	2	.....	5
10 years and under 15 years.....	18	3	5	4	5	1	.....
15 years and under 20 years.....	7	.....	2	2	1	2	.....
20 years and over.....	6	1	1	1	3	.....	.....

<sup>1</sup> See descriptive key list of hospitals on page 219.



TABLE 65

New York State (Exclusive of New York City)

Study of Patients Discharged from Hospital Wards, 1939

630 WARD PATIENTS (OBSTETRICAL PATIENTS EXCLUDED) CLASSIFIED BY INTERVAL BETWEEN FIRST MEDICAL ATTENTION AND HOSPITAL ADMISSION<sup>1</sup>

TIME INTERVAL	All hospitals	Hospital A	Hospital D	Hospital F	Hospital H	Hospital J <sub>1</sub>	Hospital J <sub>2</sub>
Total.....	630	76	192	85	94	108	75
Not reported.....	11	.....	6	1	1	2	1
Reported.....	619	76	186	84	93	106	74
Total under 1 month.....	328	56	96	50	42	66	18
under 1 month, unspecified.....	86	7	26	18	14	12	9
Under 1 day.....	116	20	40	13	17	23	3
1 day and under 2 days.....	38	10	11	3	3	10	1
2 days and under 3 days.....	17	4	2	1	5	3	2
3 days and under 4 days.....	12	2	3	4	.....	2	1
4 days and under 1 week.....	11	3	4	3	.....	1	.....
1 week and under 2 weeks.....	28	7	4	5	2	9	1
2 weeks and under 3 weeks.....	13	1	4	1	1	5	1
3 weeks and under 1 month.....	7	2	2	2	.....	1	.....
1 month and under 2 months.....	43	2	17	6	6	6	6
2 months and under 3 months.....	24	2	6	2	2	5	7
3 months and under 6 months.....	51	3	12	7	5	13	11
6 months and under 9 months.....	25	3	7	3	9	1	2
9 months and under 1 year.....	18	.....	6	.....	4	3	5
1 year and under 2 years.....	41	3	9	5	8	4	12
2 years and under 5 years.....	59	7	22	4	10	5	11
5 years and under 10 years.....	17	.....	6	2	4	3	2
10 years and under 15 years.....	5	.....	1	2	2	.....	.....
15 years and under 20 years.....	4	.....	2	2	.....	.....	.....
20 years and over.....	4	.....	2	1	1	.....	.....

<sup>1</sup> See descriptive key list of hospitals on page 219.

TABLE 66

New York State (Exclusive of New York City)

Study of Patients Discharged from Hospital Wards, 1939

630 WARD PATIENTS (OBSTETRICAL PATIENTS EXCLUDED) CLASSIFIED BY INTERVAL BETWEEN FIRST SYMPTON AND HOSPITAL ADMISSION<sup>1</sup>

TIME INTERVAL	All hospitals	Hospital A	Hospital D	Hospital F	Hospital H	Hospital J <sub>1</sub>	Hospital J <sub>2</sub>
Total.....	630	76	192	85	94	108	75
Not reported.....	13	.....	6	2	3	1	1
Reported.....	617	76	186	83	91	107	74
Total under 1 month.....	240	46	73	33	26	51	11
Under 1 month, unspecified.....	10	1	4	2	.....	.....	3
Under 1 day.....	56	8	11	9	10	16	2
1 day and under 2 days.....	42	12	12	3	5	10	.....
2 days and under 3 days.....	22	5	5	2	5	4	1
3 days and under 4 days.....	17	4	8	1	2	2	.....
4 days and under 1 week.....	23	5	10	4	1	2	1
1 week and under 2 weeks.....	41	9	13	7	3	8	1
2 weeks and under 3 weeks.....	21	1	7	3	.....	7	3
3 weeks and under 1 month.....	8	1	3	2	.....	2	.....
1 month and under 2 months.....	32	6	8	4	3	8	3
2 months and under 3 months.....	19	1	7	1	1	6	3
3 months and under 6 months.....	52	4	13	5	6	12	12
6 months and under 9 months.....	36	2	8	6	10	6	4
9 months and under 1 year.....	17	.....	4	1	3	4	5
1 year and under 2 years.....	51	4	12	11	3	5	16
2 years and under 5 years.....	102	10	38	10	23	8	13
5 years and under 10 years.....	24	.....	9	1	4	3	7
10 years and under 15 years.....	22	1	6	7	7	1	.....
15 years and under 20 years.....	10	.....	4	2	1	3	.....
20 years and over.....	12	2	4	2	4	.....	.....

<sup>1</sup> See descriptive key list of hospitals on page 219.

TABLE 67

New York State (Exclusive of New York City)

Study of Patients Discharged from Hospital Wards, 1939

141 WARD PATIENTS (OBSTETRICAL) CLASSIFIED BY MONTH OF PREGNANCY IN WHICH ANTE-PARTUM CARE, CARE BY PRIVATE PHYSICIAN AND CARE BY CLINIC BEGAN

MONTH OF PREGNANCY	Ante-partum care began	Care by private physician began	Care by clinic began
Total obstetrical cases.....	141	141	141
Cases receiving no medical attention prior to hospitalization.....	8	61	78
Total cases receiving medical care <sup>1</sup> .....	133	80	63
9th month, total.....	15	9	6
First seen by physician within 24 hours of hospitalization.....	3	3	.....
Remainder of 9th month.....	12	6	6
8th month.....	13	6	8
7th month.....	20	9	11
6th month.....	10	4	6
5th month.....	14	5	11
4th month.....	16	12	6
3rd month.....	15	11	6
2nd month.....	23	19	4
1st month.....	6	3	3
Unknown.....	1	2	2

<sup>1</sup> Ten cases received care from both private physician and clinic during the course of pregnancy.



TABLE 68

New York State (Exclusive of New York City)

Study of Patients Discharged from Hospital Wards, 1939

771 WARD PATIENTS CLASSIFIED BY INTERVAL BETWEEN HOSPITAL APPLICATION AND HOSPITAL ADMISSION <sup>1</sup>

TIME INTERVAL	Total	ALL PATIENTS, EXCEPT OBSTETRICAL PATIENTS							Obstet- rical patients, all hospitals
		All hos- pitals	Hos- pital A	Hos- pital D	Hos- pital F	Hos- pital H	Hos- pital J <sub>1</sub>	Hos- pital J <sub>2</sub>	
Total.....	771	630	76	192	85	94	108	75	141
Not reported.....	160	98	2	19	12	30	10	25	62
Hospital arrangements not made by patient or family.....	86	59	1	3	9	25	5	16	27
Unknown interval.....	74	39	1	16	3	5	5	9	35
Reported.....	611	532	74	173	73	64	98	50	79
Under 1 day.....	481	426	70	117	53	59	87	40	55
1 day and under 2 days.....	32	31	1	9	10	3	5	3	1
2 days and under 3 days.....	17	16	2	7	5	.....	1	1	4
3 days and under 4 days.....	11	7	.....	6	.....	.....	1	.....	1
4 days and under 1 week.....	18	17	.....	13	2	1	.....	1	1
1 week and under 2 weeks.....	21	13	.....	13	2	1	2	.....	3
2 weeks and under 3 weeks.....	16	14	1	5	1	.....	2	5	2
3 weeks and under 1 month.....	10	2	.....	2	.....	.....	.....	.....	8
1 month and over.....	5	1	.....	1	.....	.....	.....	.....	4

<sup>1</sup> See descriptive key list of hospitals on page 219.

TABLE 69

New York State (Exclusive of New York City)

Study of Patients Discharged from Hospital Wards, 1939

771 WARD PATIENTS CLASSIFIED BY PLACE WHERE PATIENT RECEIVED FIRST MEDICAL ATTENTION FOR ILLNESS WHICH LED TO HOSPITALIZATION <sup>1</sup>

SCENE OF FIRST MEDICAL ATTENTION	Total	ALL PATIENTS, EXCEPT OBSTETRICAL PATIENTS							Obstet- rical patients, all hospitals
		All hos- pitals	Hos- pital A	Hos- pital D	Hos- pital F	Hos- pital H	Hos- pital J <sub>1</sub>	Hos- pital J <sub>2</sub>	
Total.....	771	630	76	192	85	94	108	75	141
Not reported.....	19	18	1	4	7	2	2	2	1
Reported.....	752	612	75	188	78	92	106	73	140
Physician's office.....	335 <sup>2</sup>	264 <sup>2</sup>	44 <sup>2</sup>	48	52	34	44	42	71
Clinic.....	131	78	.....	61	1	7	6	3	53
School.....	23	23	.....	3	.....	15	1	4	.....
Hospital.....	32 <sup>3</sup>	24	3	9	.....	6	4	2	8
Patient's home.....	231 <sup>4</sup>	223 <sup>4</sup>	28 <sup>4</sup>	67	25	30	51	22	8

<sup>1</sup> See descriptive key list of hospitals on page 219.<sup>2</sup> Includes 1 dentist's office.<sup>3</sup> Includes 19 patients first seen at this hospital admission.<sup>4</sup> Includes 1 police station.

TABLE 70

New York State (Exclusive of New York City)

Study of Patients Discharged from Hospital Wards, 1939

771 WARD PATIENTS CLASSIFIED BY REASON FOR DELAY IN  
SECURING MEDICAL CARE<sup>1</sup>

REASON FOR DELAY	Total	ALL PATIENTS, EXCEPT OBSTETRICAL PATIENTS							Obstet- rical patients, all hospitals
		All hos- pitals	Hos- pital A	Hos- pital D	Hos- pital F	Hos- pital H	Hos- pital J <sub>1</sub>	Hos- pital J <sub>2</sub>	
Total.....	771	630	76	192	85	94	108	75	141
Not reported.....	31	26	2	19	1	4	....	....	5
Reported.....	740	604	74	173	84	90	108	75	136
No delay.....	347	301	41	70	40	40	71	39	46
Total delayed.....	393	303	33	103	44	50	37	36	90
Self neglect.....	47	33	6	4	10	8	3	2	14
Did not realize necessity.....	181	136	15	48	24	12	17	20	45
Unable to pay for medical care.....	122 <sup>2</sup>	99	10	37	6	21	14	11	23 <sup>2</sup>
Unable to pay for medical care and self neglect.....	6	4	....	3	1	....	....	....	2
Unable to pay for medical care and did not realize necessity.....	16	14	1	6	1	3	3	....	2
Other reasons <sup>3</sup> .....	21	17	1	5	2	6	....	3	4

<sup>1</sup> See descriptive key list of hospitals on page 219.<sup>2</sup> Includes 2 which state also "free clinic not available."<sup>3</sup> Other reasons include: refused welfare authorization (3), refused free care by private physician (2), refused free care by city physician (1), physician not available (2), waited for appointment at special rate (4), roads impassable (1), delayed operation until summer (2), father would not allow tonsillectomy (1), thought tonsils would grow back if operated before five years of age (1), away on trip (1), ashamed to have pelvic examination (1), Christian Scientist (1), treated by nurse at child caring institution (1).

TABLE 71 AND 71 Combined

New York State (Exclusive of New York City)

Study of Patients Discharged from Hospital Wards, 1939

771 WARD PATIENTS CLASSIFIED BY (A) TYPE OF SELF-MEDICATION EMPLOYED FOR ILLNESS LEADING TO THIS HOSPITALIZATION AND (B) SOURCE OF RECOMMENDATION OF REMEDY USED FOR SELF-MEDICATION <sup>1</sup>

(A) TYPE OF SELF-MEDICATION	Total	ALL PATIENTS, EXCEPT OBSTETRICAL PATIENTS							Obstet- rical patients, all hospitals
		All hos- pitals	Hos- pital A	Hos- pital D	Hos- pital F	Hos- pital H	Hos- pital J <sub>1</sub>	Hos- pital J <sub>2</sub>	
Total .....	771	630	76	192	85	94	108	75	141
Not reported .....	14	14	6	1	.....	6	.....	1	.....
Reported .....	757	616	70	191	85	88	108	74	141
No self-medication .....	551	416	44	115	57	66	79	55	135
Total self-medication .....	206	200	26	76	28	22	29	19	6
USP medication only .....	59	57	15	17	8	3	9	5	2
USP and proprietary medication .....	37	35	6	16	2	3	5	3	2
USP, proprietary medication and appli- cances .....	2	2	.....	2	.....	.....	.....	.....	.....
USP medication and appliances .....	5	5	.....	2	1	1	1	.....	.....
Proprietary medication only .....	60	58	2	22	6	11	7	10	2
Proprietary medication and appliances .....	7	7	.....	5	1	1	.....	.....	.....
Appliances only .....	29	29	1	11	6	3	7	1	.....
Other self-medication <sup>2</sup> .....	7	7	2	1	4	.....	.....	.....	.....
(B) SOURCE OF RECOMMENDATION									
Total self-medication .....	206	200	26	76	28	22	29	19	6
Self <sup>3</sup> .....	37	37	8	4	13	2	7	3	.....
Family .....	110	105	11	53	8	9	15	9	5
Neighbor .....	12	12	2	5	2	2	1	.....	.....
Druggist .....	11	11	2	3	2	3	.....	1	.....
Newspaper .....	3	3	.....	1	1	1	.....	.....	.....
Radio .....	2	2	.....	1	.....	.....	1	.....	.....
Other source <sup>4</sup> .....	11	10	2	5	1	1	.....	1	1
Unknown source .....	20	20	1	4	1	4	5	5	.....

<sup>1</sup> See descriptive key list of hospitals on page 219.<sup>2</sup> Includes self-medication, not specified (3), dietary regulation (2), smoke and oil in ear (1), tried to remove splinter (1).<sup>3</sup> Patient failed to indicate primary source of suggestion.<sup>4</sup> Includes nurse (3), physician for previous illness (2), written source and neighbor (2), dentist (1) salesman and family (1), druggist and family (1), neighbor, family, druggist and radio (1).

TABLE 72

New York State (Exclusive of New York City)

Study of Patients Discharged from Hospital Wards, 1939

771 WARD PATIENTS CLASSIFIED BY STATEMENT REGARDING  
REGULAR FAMILY PHYSICIAN<sup>1</sup>

REGULAR FAMILY PHYSICIAN	Total	ALL PATIENTS, EXCEPT OBSTETRICAL PATIENTS							Obstet- rical patients, all hospitals
		All hos- pitals	Hos- pital A	Hos- pital D	Hos- pital F	Hos- pital H	Hos- pital J <sub>1</sub>	Hos- pital J <sub>2</sub>	
Total.....	771	630	76	102	85	94	108	75	141
Not reported.....	4	2	....	2	....	....	....	....	2
Reported.....	767	628	76	100	85	94	108	75	139
Have regular family physician.....	463	399	55	89	60	58	80	57	64
Have no regular family physician.....	304	229	21	101	25	36	28	18	75

<sup>1</sup> See descriptive key list of hospitals on page 219.



TABLE 73

## New York State (Exclusive of New York City)

## Study of Patients Discharged from Hospital Wards, 1939

771 WARD PATIENTS CLASSIFIED BY CONTENT <sup>2</sup> OF PHYSICAL EXAMINATION PRIOR TO THIS ILLNESS AS REPORTED BY PATIENT <sup>1</sup>

CONTENT OF PHYSICAL EXAMINATION BY MINIMAL PROCEDURES <sup>3</sup>	Total	PATIENTS, EXCLUDING OBSTETRICAL							Obstetrical patients, all hospitals
		All hospitals	Hospital A	Hospital D	Hospital F	Hospital H	Hospital J <sub>1</sub>	Hospital J <sub>2</sub>	
Total.....	771	630	76	192	85	94	108	75	141
Uncertain physical examination.....	33	33	1	27	2	....	1	2	.....
Reported.....	738	597	75	165	83	94	107	73	141
No physical examination.....	315	237	35	69	38	31	42	22	78
Total physical examinations.....	423	360	40	96	45	63	65	51	63
Complete minimal physical examination.....	137	113	6	42	20	6	24	15	24
Part of minimal physical examination.....	187	155	21	42	15	21	31	25	32
None of minimal physical examination but other procedures.....	32	30	9	2	2	16	1	....	2
Unknown content of physical examination.....	67	62	4	10	8	20	9	11	5
CONTENT OF PHYSICAL EXAMINATION BY LABORATORY TESTS <sup>4</sup>									
Total physical examinations.....	423	360	40	96	45	63	65	51	63
Laboratory tests performed.....	225	177	17	59	22	18	41	20	48
No laboratory tests reported.....	131	121	19	27	15	25	15	20	10
Unknown content of physical examination.....	67	62	4	10	8	20	9	11	5

<sup>1</sup> See descriptive key list of hospitals on page 219.<sup>2</sup> The schedule contained the following items:

# All parts of body examined.	Genital exam. in males.	x Blood count.
# Clothes removed.	Vaginal exam. in females.	x Blood test (Wasserman).
# Use of stethoscope.	Rectal exam.	x X-rays.
# Blood pressure reading.	x Urinalysis.	x Sputum exam.
		Other (specify).

<sup>3</sup> The # items above are considered "minimal physical examination" for the purpose of this study.<sup>4</sup> The x items above are considered "laboratory tests."

TABLE 74

New York State (Exclusive of New York City)

Study of Patients Discharged from Hospital Wards, 1939

771 WARD PATIENTS CLASSIFIED BY (A) PLACE WHERE PHYSICAL EXAMINATION DESCRIBED IN TABLE 73 WAS PERFORMED AND (B) WHETHER THIS EXAMINATION WAS PERFORMED BY PRIVATE PHYSICIAN <sup>1</sup>

(A) SCENE OF EXAMINATION	Total	ALL PATIENTS, EXCEPT OBSTETRICAL PATIENTS							Obstet- rical patients, all hospitals
		All hos- pitals	Hos- pital A	Hos- pital D	Hos- pital F	Hos- pital H	Hos- pital J <sub>1</sub>	Hos- pital J <sub>2</sub>	
Total.....	771	630	76	192	85	94	108	75	141
Uncertain physical examination.....	33	33	1	27	2	....	1	2	.....
No physical examination.....	315	237	35	69	38	31	42	22	78
Total examined.....	423	360	40	96	45	63	65	51	63
Not reported.....	39	31	2	9	9	4	6	1	8
Reported.....	384	329	38	87	36	59	59	50	55
Physician's office.....	128	102	18	16	13	13	24	18	26
Health department clinic.....	4	4	....	....	1	3	....	....	.....
Industrial clinic.....	12	12	2	3	4	2	....	1	.....
Other clinic, including out-patient department of hospital.....	65	48	1	24	3	5	7	8	17
School.....	85	80	14	12	5	29	6	14	5
Hospital.....	61	55	3	20	6	5	16	5	6
Patient's home.....	15	15	....	9	1	2	2	1	.....
Other <sup>1</sup> .....	14	13	....	3	3	....	4	3	1
(B) PHYSICIAN MAKING EXAMINATION									
Total examined.....	423	360	40	96	45	63	65	51	63
Not reported.....	36	30	4	6	8	7	4	1	6
Reported.....	387	330	36	90	37	56	61	50	57
Examined by private physician.....	160	129	16	31	17	15	30	20	31
Examined by other physician.....	227	201	20	59	20	41	31	30	26

<sup>1</sup> See descriptive key list of hospitals on page 219.<sup>2</sup> Other places include United States Army (8), United States Navy (1), Civilian Conservation Corps (1), Immigration Station (1), City Hall (1), and New York City Department of Water Supply (1).

TABLE 75

New York State (Exclusive of New York City)  
 Study of Patients Discharged from Hospital Wards, 1939  
 771 WARD PATIENTS CLASSIFIED BY STATEMENT REGARDING  
 PERIODIC PHYSICAL EXAMINATION<sup>1</sup>

PERIODIC PHYSICAL EXAMINATION	Total	ALL PATIENTS, EXCEPT OBSTETRICAL PATIENTS							Obstet- rical patients, all hospitals
		All hos- pitals	Hos- pital A	Hos- pital D	Hos- pital F	Hos- pital H	Hos- pital J <sub>1</sub>	Hos- pital J <sub>2</sub>	
Total.....	771	630	76	192	85	94	108	75	141
No evidence of periodic examination.....	660	521	62	160	79	72	89	59	139
Periodic examination reported.....	111	109	14	32	6	22	19	16	2
Examined every year.....	67	67	10	18	3	21	4	11	.....
Examined twice a year.....	11	10	.....	4	.....	.....	5	1	1
Examined more frequently than twice a year.....	20	20	2	5	1	.....	9	3	.....
Examined at unknown intervals.....	13	12	2	5	2	1	1	1	1

<sup>1</sup> See descriptive key list of hospitals on page 219.

TABLE 76

New York State (Exclusive of New York City)

Study of Patients Discharged from Hospital Wards, 1939

630 WARD PATIENTS (EXCLUDING OBSTETRICAL PATIENTS) CLASSIFIED BY DURATION OF CARE BY PRIVATE PHYSICIAN FOR THIS ILLNESS<sup>1</sup>

DURATION OF CARE	All hospitals	Hospital A	Hospital D	Hospital F	Hospital H	Hospital J <sub>1</sub>	Hospital J <sub>2</sub>
Total.....	630	76	192	85	94	108	75
No care by private physician prior to hospitalization.....	125	.....	81	1	29	8	6
Total patients cared for by private physician prior to hospitalization.....	505	76	111	84	65	100	69
Unknown duration of care.....	10	1	7	.....	2	.....	.....
Duration of care known.....	495	75	104	84	63	100	69
Total under 1 month.....	302	59	68	51	44	58	22
Under 1 day.....	86	26	14	17	21	6	2
1 day and under 2 days.....	84	8	28	4	10	23	11
2 days and under 3 days.....	34	4	6	5	7	10	2
3 days and under 4 days.....	20	7	1	5	2	4	1
4 days and under 1 week.....	14	4	5	3	.....	1	1
1 week and under 2 weeks.....	35	8	5	10	3	7	2
2 weeks and under 3 weeks.....	22	2	7	4	1	5	3
3 weeks and under 1 month.....	7	.....	2	3	.....	2	.....
1 month and under 2 months.....	35	2	5	9	4	8	7
2 months and under 3 months.....	18	4	1	2	3	2	6
3 months and under 6 months.....	36	2	8	4	3	12	7
6 months and under 9 months.....	16	2	2	3	2	2	5
9 months and under 1 year.....	7	.....	1	3	1	1	1
1 year and under 2 years.....	27	1	5	6	1	6	8
2 years and under 5 years.....	28	3	7	2	2	6	8
5 years and under 10 years.....	17	1	5	2	2	4	3
10 years and under 15 years.....	6	.....	1	1	1	1	2
15 years and under 20 years.....	1	1	.....	.....	.....	.....	.....
20 years and over.....	2	.....	1	1	.....	.....	.....

<sup>1</sup> See descriptive key list of hospitals on page 219.



TABLE 77

New York State (Exclusive of New York City)

Study of Patients Discharged from Hospital Wards, 1939

771 WARD PATIENTS CLASSIFIED BY CONSULTATIONS OBTAINED  
BY PRIVATE PHYSICIANS<sup>1</sup>

CONSULTANT	Total	ALL PATIENTS, EXCEPT OBSTETRICAL PATIENTS							Obstet- rical patients, all hospitals
		All hos- pitals	Hos- pital A	Hos- pital D	Hos- pital F	Hos- pital H	Hos- pital J <sub>1</sub>	Hos- pital J <sub>2</sub>	
Total.....	771	630	76	192	85	94	108	75	141
Not cared for by private physician prior to hospitalization.....	186	125	....	81	1	29	8	6	61
Cared for by private physician.....	585	505	76	111	84	65	100	69	80
Not reported.....	17	15	3	6	....	4	2	....	2
Reported.....	568	490	73	105	84	61	98	69	78
Physician called consultant.....	54	52	11	6	14	1	16	4	2
Physician did not call consultant....	514	438	62	99	70	60	82	65	76

<sup>1</sup> See descriptive key list of hospitals on page 219.

TABLE 78

New York State (Exclusive of New York City)

Study of Patients Discharged from Hospital Wards, 1939<sup>1</sup>771 WARD PATIENTS CLASSIFIED BY CONTENT<sup>2</sup> OF PHYSICAL EXAMINATION BY PRIVATE PHYSICIAN FOR THIS ILLNESS AS REPORTED BY PATIENT

CONTENT OF PHYSICAL EXAMINATION BY MINIMAL PROCEDURES <sup>3</sup>	Total	ALL PATIENTS, EXCEPT OBSTETRICAL PATIENTS							Obstetrical patients, all hospitals
		All hospitals	Hospital A	Hospital D	Hospital F	Hospital H	Hospital J <sub>1</sub>	Hospital J <sub>2</sub>	
Total.....	771	630	76	192	85	94	108	75	141
Not cared for by private physician prior to hospitalization.....	186	125	....	81	1	29	8	6	61
Cared for by private physician.....	585	505	76	111	84	65	100	69	80
No definite report of physical examination by private physician <sup>4</sup> .....	83	75	11	20	13	19	10	2	8
Total physical examinations.....	502	430	65	91	71	46	90	67	72
Complete minimal physical examination.....	94	73	5	24	11	2	19	12	21
Part of minimal physical examination	248	199	16	54	29	22	44	34	49
None of minimal physical examination but other procedures.....	158	156	44	13	31	21	26	21	2
Unknown content of physical examination.....	2	2	....	....	....	1	1	....	.....
CONTENT OF PHYSICAL EXAMINATION BY LABORATORY TESTS <sup>5</sup>									
Total physical examinations.....	502	430	65	91	71	46	90	67	72
Laboratory tests performed.....	233	187	28	46	28	12	34	19	66
No laboratory tests reported.....	267	261	37	45	43	33	55	48	6
Unknown content of physical examination.....	2	2	....	....	....	1	1	....	.....

<sup>1</sup> See descriptive key list of hospitals on page 219.<sup>2</sup> The schedule contained the following items:

# All parts of body examined.	Genital exam. in males.	x Blood count.
# Clothes removed.	Vaginal exam. in females.	x Blood test (Wasserman).
# Use of stethoscope.	Rectal exam.	x Sputum exam.
# Blood pressure reading.	x Urinalysis.	Other (specify).

<sup>3</sup> The # items above are considered "minimal physical examination" for the purpose of this study.<sup>4</sup> Includes 13 patients uncertain as to whether physical examination was performed.<sup>5</sup> The x items above are considered "laboratory tests."

TABLE 79

New York State (Exclusive of New York City)

Study of Patients Discharged from Hospital Wards, 1939

141 WARD PATIENTS (OBSTETRICAL) CLASSIFIED BY CONTENT<sup>1</sup> OF PHYSICAL EXAMINATION BY PRIVATE PHYSICIAN DURING THIS PREGNANCY AS REPORTED BY PATIENT

CONTENT OF PHYSICAL EXAMINATION	Obstetrical patients	Percent
Total.....	141	100.0
Not cared for by private physician prior to hospitalization..	61	43.3
Cared for by private physician.....	80	56.7
No physical examination prior to hospitalization.....	8	.....
Total physical examinations.....	72	100.0
All four tests completed.....	32	44.4
Three of specified tests completed.....	20	27.8
Two of specified tests completed.....	15	20.8
Only one of specified tests completed.....	4	5.6
None of specified tests completed.....	1	1.4
Total.....	72	100.0
Blood pressure done.....	68	94.4
Blood pressure not done.....	4	5.6
Total.....	72	100.0
Vaginal examination done.....	40	55.6
Vaginal examination not done.....	32	44.4
Total.....	72	100.0
Urinalysis done.....	64	88.9
Urinalysis not done.....	8	11.1
Total.....	72	100.0
Blood test done.....	50	69.4
Blood test not done.....	22	30.6

<sup>1</sup> Analyzed in terms of procedures considered essential to prenatal care.

TABLE 80

New York State (Exclusive of New York City)

Study of Patients Discharged from Hospital Wards, 1939

771 WARD PATIENTS CLASSIFIED BY METHOD OF PAYMENT FOR SERVICES OF PRIVATE PHYSICIAN PRIOR TO HOSPITALIZATION FOR THIS ILLNESS<sup>1</sup>

METHOD OF PAYMENT FOR PRIVATE PHYSICIAN'S SERVICES	Total	ALL PATIENTS, EXCEPT OBSTETRICAL PATIENTS							Obstet- rical patients, all hospitals
		All hos- pitals	Hos- pital A	Hos- pital D	Hos- pital F	Hos- pital H	Hos- pital J <sub>1</sub>	Hos- pital J <sub>2</sub>	
Total.....	771	630	76	192	85	94	108	75	141
No care by private physician prior to hospitalization.....	186	125	....	81	1	29	8	6	61
Total patients cared for by private physi- cian prior to hospitalization.....	585	505	76	111	84	65	100	69	80
Not reported as to payment for physician's services.....	6	6	3	1	1	1	....	....	....
Method of payment reported.....	579	499	73	110	83	64	100	69	80
Patient assumed responsibility.....	427	352	52	83	63	29	78	47	75
With credit from physician.....	332	277	47	44	54	16	72	44	55
Without credit from physician.....	70	52	3	28	9	4	6	2	18
Unknown as to credit.....	25	23	2	11	....	9	....	1	2
Other agency <sup>2</sup> assumed responsibility..	124	123	17	18	19	31	19	19	1
Patient and other agency shared respon- sibility.....	12	11	3	3	1	1	1	2	1
Free care by physician.....	16	13	1	6	....	3	2	1	3

<sup>1</sup> See descriptive key list of hospitals on page 219.<sup>2</sup> Includes such agencies as public welfare, compensation fund, industrial fund and private welfare.



TABLE 81

## New York State (Exclusive of New York City)

Study of Patients Discharged from Hospital Wards, 1939<sup>1</sup>630 WARD PATIENTS (EXCLUDING OBSTETRICAL PATIENTS) CLASSIFIED BY DURATION OF CLINIC CARE PRIOR TO HOSPITALIZATION FOR THIS ILLNESS<sup>1</sup>

DURATION OF CARE	All hospitals	Hospital A	Hospital D	Hospital F	Hospital H	Hospital J <sub>1</sub>	Hospital J <sub>2</sub>
Total.....	630	76	192	85	94	108	75
No clinic care prior to hospitalization.....	476	76	77	83	86	100	54
Total patients cared for at clinics prior to hospitalization.....	154	.....	115	2	8	8	21
Unknown duration of care.....	19	.....	10	1	3	1	4
Duration of care known.....	135	.....	105	1	5	7	17
Total under 1 month.....	72	.....	57	1	3	4	7
Under 1 day.....	15	.....	12	1	1	1	.....
1 day and under 2 days.....	30	.....	21	.....	1	3	5
2 days and under 3 days.....	2	.....	2	.....	.....	.....	.....
3 days and under 4 days.....	4	.....	4	.....	.....	.....	.....
4 days and under 1 week.....	1	.....	.....	.....	1	.....	.....
1 week and under 2 weeks.....	10	.....	9	.....	.....	.....	1
2 weeks and under 3 weeks.....	6	.....	5	.....	.....	.....	1
3 weeks and under 1 month.....	4	.....	4	.....	.....	.....	.....
1 month and under 2 months.....	17	.....	13	.....	.....	1	3
2 months and under 3 months.....	8	.....	7	.....	.....	.....	1
3 months and under 6 months.....	15	.....	13	.....	.....	1	1
6 months and under 9 months.....	6	.....	4	.....	1	.....	1
9 months and under 1 year.....	.....	.....	.....	.....	.....	.....	.....
1 year and under 2 years.....	7	.....	3	.....	.....	1	3
2 years and under 5 years.....	10	.....	8	.....	1	.....	1

<sup>1</sup> See descriptive key list of hospitals on page 319.

TABLE 82

## New York State (Exclusive of New York City)

Study of Patients Discharged from Hospital Wards, 1939

771 WARD PATIENTS CLASSIFIED BY PATIENT'S REPORT OF DELAY IN HOSPITAL ADMISSION<sup>1</sup>

DELAY IN HOSPITAL ADMISSION	Total	ALL PATIENTS, EXCEPT OBSTETRICAL PATIENTS							Obstetrical patients, all hospitals
		All hospitals	Hospital A	Hospital D	Hospital F	Hospital H	Hospital J <sub>1</sub>	Hospital J <sub>2</sub>	
Total.....	771	630	76	192	85	94	108	75	141
Not reported.....	12	11	3	1	5	2	.....	.....	1
Reported.....	759	619	73	191	80	92	108	75	140
No delay in hospital admission.....	687	547	72	145	76	84	104	66	140
Delay in hospital admission.....	72	72	1	46	4	8	4	9	.....
Waiting for special rate.....	12	12	.....	.....	.....	7	1	4	.....
Other reason for delay.....	60	60	1	46	4	1	3	5	.....

<sup>1</sup> See descriptive key list of hospitals on page 219.

TABLE 83

New York State (Exclusive of New York City)

Study of Patients Discharged from Hospital Wards, 1939

771 WARD PATIENTS CLASSIFIED BY MEDICAL CARE FOLLOWING HOSPITAL DISCHARGE<sup>1</sup>

MEDICAL CARE	Total	ALL PATIENTS, EXCEPT OBSTETRICAL PATIENTS							Obstet- rical patients, all hospitals
		All hos- pitals	Hos- pital A	Hos- pital D	Hos- pital F	Hos- pital H	Hos- pital J <sub>1</sub>	Hos- pital J <sub>2</sub>	
Total.....	771	630	76	192	85	94	108	75	141
Died in hospital.....	24	23	6	4	1	1	7	4	1
Surviving patients.....	747	607	70	188	84	93	101	71	140
Not reported.....	2	2	.....	1	.....	1	.....	.....	.....
Reported.....	745	605	70	187	84	92	101	71	140
No further medical care.....	191	140	8	29	7	54	19	23	51
Medical care.....	554	465	62	158	77	38	82	48	89
Physician only.....	315	277	59	14	75	25	70	34	38
Physician and nursing service.....	13	9	.....	1	2	3	1	2	4
Clinic only.....	160	145	.....	126	.....	1	7	11	15
Clinic and nursing service.....	24	10	.....	8	.....	1	1	.....	14
Nursing service only.....	30	12	1	4	.....	7	.....	.....	18
Physician and clinic.....	4	4	.....	3	.....	.....	1	.....	.....
Other <sup>2</sup> .....	8	8	2	2	.....	1	2	1	.....

<sup>1</sup> See descriptive key list of hospitals on page 219.<sup>2</sup> Includes hospital (4), non-medical institute (3), non-medical institute and physician (1).

TABLE 84

New York State (Exclusive of New York City)

Study of Patients Discharged from Hospital Wards, 1939

771 WARD PATIENTS CLASSIFIED BY INDIVIDUAL ANNUAL CASH INCOME<sup>2</sup> REPORTED<sup>1</sup>

INDIVIDUAL INCOME	Total	ALL PATIENTS, EXCEPT OBSTETRICAL PATIENTS							Obstet- rical patients, all hospitals
		All hos- pitals	Hos- pital A	Hos- pital D	Hos- pital F	Hos- pital H	Hos- pital J <sub>1</sub>	Hos- pital J <sub>2</sub>	
Total.....	771	630	76	192	85	94	108	75	141
Not reported.....	33	32	8	16	3	.....	5	.....	1
Reported.....	738	598	68	176	82	94	103	75	140
No cash income.....	542 <sup>3</sup>	406	44	105	55	71	75	56	136
Relief only.....	65	64	4	18	5	15	7	15	1
Under \$400.....	33	31	4	15	5	2	5	.....	2
\$400 and under \$600.....	29	28	8	10	1	3	4	2	1
600 and under 800.....	28	28	4	11	7	2	4	.....	.....
800 and under 1,000.....	7	7	1	3	1	.....	2	.....	.....
1,000 and under 1,500.....	25	25	2	8	7	1	6	1	.....
1,500 and under 2,000.....	8	8	1	6	1	.....	.....	.....	.....
2,000 and over.....	1	1	.....	.....	.....	.....	.....	1	.....

<sup>1</sup> See descriptive key list of hospitals on page 219.<sup>2</sup> Cash income includes WFA wage, pension or relief allowance when supplementing other income source.<sup>3</sup> Includes all non-workers.

TABLE 85

New York State (Exclusive of New York City)  
Study of Patients Discharged from Hospital Wards, 1939  
771 WARD PATIENTS CLASSIFIED BY FAMILY ANNUAL  
CASH INCOME<sup>2</sup> REPORTED<sup>1</sup>

FAMILY GROUP INCOME	Total	ALL PATIENTS, EXCEPT OBSTETRICAL PATIENTS							Obstet- rical patients, all hospitals
		All hos- pitals	Hos- pital A	Hos- pital D	Hos- pital F	Hos- pital H	Hos- pital J <sub>1</sub>	Hos- pital J <sub>2</sub>	
Total.....	771	630	76	192	85	94	108	75	141
Not reported.....	126	109	22	38	19	15	8	7	17
Reported.....	645	521	54	154	66	79	100	68	124
No cash income.....	17	16	2	4	2	1	5	2	1
Relief only.....	74	66	4	23	3	11	14	11	8
Under \$400.....	53	50	8	12	6	15	3	6	8
\$400 and under \$600.....	72	60	8	16	6	15	12	3	12
600 and under 800.....	131	102	9	33	11	14	21	14	29
800 and under 1,000.....	63	51	9	16	7	8	8	3	12
1,000 and under 1,500.....	153	112	10	35	16	13	20	18	41
1,500 and under 2,000.....	52	40	4	8	8	2	12	6	12
2,000 and over.....	25	24	....	7	7	....	5	5	1

<sup>1</sup> See descriptive key list of hospitals on page 219.<sup>2</sup> Cash income includes WPA wage, pensions or relief allowance when supplementing other income source.

TABLE 86

New York State (Exclusive of New York City)  
Study of Patients Discharged from Hospital Wards, 1939  
771 WARD PATIENTS CLASSIFIED BY INTERVAL BETWEEN  
HOSPITAL DISCHARGE DATE AND INTERVIEW<sup>1</sup>

TIME INTERVAL	Total	ALL PATIENTS, EXCEPT OBSTETRICAL PATIENTS							Obstet- rical patients, all hospitals
		All hos- pitals	Hos- pital A	Hos- pital D	Hos- pital F	Hos- pital H	Hos- pital J <sub>1</sub>	Hos- pital J <sub>2</sub>	
Total.....	771	630	76	192	85	94	108	75	141
Not reported.....	8	7	....	....	2	2	3	....	1
Reported.....	763	623	76	192	83	92	105	75	140
1 month and under 2 months.....	103	98	37	44	5	11	....	1	5
2 months and under 3 months.....	113	109	16	43	19	9	14	8	4
3 months and under 4 months.....	137	125	14	22	19	18	34	18	12
4 months and under 5 months.....	145	118	9	34	11	20	20	24	27
5 months and under 6 months.....	124	92	....	32	15	6	18	21	32
6 months and under 7 months.....	64	43	....	12	11	9	8	3	21
7 months and under 8 months.....	40	16	....	4	2	2	8	....	24
8 months and under 9 months.....	35	20	....	1	1	16	2	....	15
9 months and under 10 months.....	2	2	....	....	....	1	1	....	....

<sup>1</sup> See descriptive key list of hospitals on page 219.

## Chapter IV

### Pay Status of Patients in Hospital Wards and Clinics in New York State, November, 1939

#### Introduction

This study was undertaken to determine the classification of patients in the wards of general hospitals and the extent to which they were expected to meet the cost of their hospital care. Information to correlate with the pay status was sought concerning whether these patients were receiving relief, working for Work Projects Administration wages or had no relief or WPA status. The month of November was selected as a sample month because at this season morbidity is usually neither very high nor very low. For the purpose of study it was decided to use information from the voluntary member hospitals of the Hospital Association of Greater New York to represent hospitals of New York City and from the upstate member hospitals of the New York State Hospital Association as a sample for upstate New York. The questionnaires used in this study are in Appendices J and K on pages 468; 472.

Information was requested concerning the ward cases accepted for treatment by these hospitals during the month of November, 1939. Counts of the following were requested:

- Patients receiving public relief.

- Patients receiving WPA wages.

- Patients receiving neither public relief nor WPA wages.

Information was requested for each of these income source groups concerning the number of patients whose hospital care was paid for by each of the following methods:

- Patient expected to pay the full ward rate.

- Patient expected to pay partial ward rate.

- Accepted as public charge.

- Referred to public welfare department (in New York City, hospital department) and decision still pending regarding authorization at public expense.

- Accepted as free case by the hospital.

- Pay status not determined by the hospital.

Responsibility for the hospitalization of public charges in upstate New York falls in most instances on the local department of public welfare. The situation is different in New York City where this responsibility rests with the City Department of Hospitals.

The 26 hospitals under the jurisdiction of the New York City Department of Hospitals were not canvassed. The New York City Department of Hospitals, in addition to maintaining a municipal



hospital system, is empowered to consider and accept as public charges, patients both with and without relief status and to reimburse voluntary and proprietary hospitals for their care. Voluntary hospitals, when the patient himself is unable to pay, may elect to apply for such reimbursement, refer the patient to a city hospital for care or accept patients as free charity ward cases.

Hospitals in upstate New York and voluntary hospitals in New York City were also asked to submit similar data concerning the patients applying for treatment at their out-patient departments during November 1939. (See Appendices J and K.)

The information submitted relating to pay status was more complete than that relating to income source. Hospital administrative statistics ordinarily emphasize pay status rather than patients' income sources.

### Analysis of Hospital Data

Only general hospitals were considered in the analysis presented at this time although special and institutional hospital members of the associations were canvassed as well. The latter formed a small diverse group with special problems which made comparisons difficult.

For the purpose of this study: a hospital ward bed was defined, in accordance with the practice of the State Department of Social Welfare, as a hospital bed or crib in a room containing five or more such beds or cribs. The basis for distributing hospitals according to size of hospital was total beds, exclusive of bassinets, as reported in the *Journal of the American Medical Association*, March 11, 1939. Type of control for each hospital was taken from the same source of information.

The full ward rate is that fee established by the hospital as a standard charge for paying patients receiving ward accommodations. This does not usually cover the full cost to the hospital. Some patients, at the discretion of the hospital, are charged only a part of the standard ward rate and the difference is assumed by the hospital. Agreement on the part of a patient to pay at either full or part ward rate does not necessarily mean that the hospital collects the entire amount due.

Hospital charges for ward patients who cannot pay may be referred to public welfare officials. Such patients are considered accepted public charges when authorization by the appropriate welfare official is given. Since the schedule was called in shortly after the hospitalizations studied, acceptance as public charges was still pending for many patients.

Another group of patients unable to pay any of the costs of hospitalization consisted of those given free care by the hospital on a charitable basis. There remained a small group of patients for whom the hospital at the time of reporting had not determined pay status.

The following "Explanatory notes on 'Relief Status of Patients'" were carried on the face of the questionnaire to secure uniformity of interpretation:

" 'Receiving public relief.' Enter cases where the patient immediately prior to admission to the hospital was receiving public relief, or where patient is a member of family currently receiving public relief, such as home relief, veteran relief, old age assistance, assistance to the blind, aid to dependent children, or care in a boarding home or institution."

" 'On WPA.' Enter cases where the patient immediately prior to this illness was employed on WPA or where some other member of his family is currently employed on WPA. If a WPA recipient is also receiving home relief, classify under WPA only."

Because of the different administrative procedure in New York City, the schedule for the New York City section of the survey differed from the one used for upstate New York by the subdivision of the remaining income source group "Non relief non WPA", into two categories:

1. Referred to or accepted by the New York City Department of Hospitals as public charges to receive hospital care.
2. Not referred to nor accepted by the New York City Department of Hospitals as public charges to receive hospital care.

#### Hospital Ward Patients—New York State (Exclusive of New York City)

Table 87 shows the distribution of the 170 member hospitals of the New York State Hospital Association canvassed. These hospitals maintain a total of 8,374 ward beds. After eliminating 26 special and institutional hospitals with 667 ward beds, which include Federal general hospital beds, there remain 144 general hospitals with a total of 7,707 ward beds.

Thirty-seven general hospitals with a ward bed capacity of 2,425 failed to reply to the questionnaire and 44 general hospitals with a total of 2,213 ward beds presented data which was either incomplete or internally inconsistent and, therefore, could not be used in the final compilation.

Table 88 includes data secured from 63 general hospitals in New York State, exclusive of New York City, which have a total ward bed capacity of 3,069. The general hospitals considered in this tabulation constituted, as may be seen from Table 87, an acceptable sample of all the general hospitals canvassed. The hospital sample used in the compilation is made up of representative proportions of voluntary and publicly controlled hospitals and contains 43.7 percent of the hospitals and 39.8 percent of the ward beds among the general hospitals canvassed. A distribution of numbers of hospitals and of ward beds according to size of hospital is given, but no definite conclusion as to adequacy of sample on this basis

can be drawn because of the large number of hospitals not reporting the number of their ward beds.

The study of these hospitals covers the hospitalization of 7,208 patients who received ward care during the month of November, 1939. In Table 88a composite figures for all hospitals considered in upstate New York are presented. The derivative Tables, 88b through 88e, consist of percent distributions based on these data.

Of the 7,208 patients, 33.7 percent were receiving public relief other than medical or hospital care, 4.5 percent were among families receiving WPA wages and 61.8 percent were listed as not receiving public relief or working on WPA (see Table 88b). Since the WPA group appears lower than might be expected in proportion to the number of relief recipients, it is conceivable that the group recorded as not receiving public relief or working on WPA is weighted with unidentified WPA workers.

Over 50 percent of all ward patients in the upstate hospitals in the study were recorded as expected to contribute toward the cost of their hospitalization (see Table 88c). Of these expected to pay, 85.5 per cent were expected to pay the full ward rate, and the remainder were expected to pay partial ward rate (see Table 88d).

Forty-four percent of all patients were referred to public welfare officials (see Table 88c). Eighty-three and four-tenths percent of these had been accepted as public charges at the time of reporting; for the remainder the decision concerning acceptance was still pending (see Table 88e).

Only 2.3 percent of all the patients were reported as receiving free charity ward service in the hospitals tabulated for upstate New York (see Table 88c). All of these patients were treated in voluntary hospitals. For more than 3 percent of patients the pay status had not been determined by the hospitals.

Seventy-nine and seven-tenths percent of the patients with neither relief nor WPA status were expected to contribute toward the cost of their hospitalization (see Table 88c). Eighty-five and eight-tenths percent of this group were expected to pay the full ward rate (see Table 88d). Thirteen and four-tenths percent of the non-relief, non-WPA group had been referred to public welfare officials and 67.1 percent of those referred had already been accepted as public charges (see Table 88e). Two and eight-tenths percent of this income source group were accepted by the hospital for free care. The hospitals had not determined the pay status of 4.1 percent of non-relief, non-WPA group of patients.

Of the patients already receiving public relief, only 1.7 percent were recorded as expected to contribute to the cost of their hospitalization. Ninety-five percent of the relief recipients had been referred to public welfare officials (see Table 88c) of whom 87.8 percent had already been accepted (see Table 88e). One and seven-tenths percent of relief recipients were given free care by the hospitals and the pay status of 1.6 percent had not been determined by the hospitals (see Table 88c).



Patients employed on WPA projects appear to be an intermediate group in respect to their hospitalization pay status. Fourteen and nine-tenths percent of the WPA group were expected to contribute to the cost of their hospitalization (see Table 88c), 56.3 percent of whom were expected to pay full ward rates (see Table 88d), 83.2 percent had been referred to public welfare officials (see Table 88c) and 81.3 percent of those referred had already been accepted as public charges (see Table 88e).

Of the patients expected to pay the full ward rate, 97.8 percent were receiving neither relief nor WPA wages (see Table 88b). Ninety-five and eight-tenths percent of the group expected to pay partial ward rates belonged to the same income source category.

On the other hand, 76.7 percent of the patients accepted as public charges for hospitalization were relief recipients (see Table 88b). Three-quarters of the patients accepted for free care by the hospitals were neither relief recipients nor on WPA (see Table 88b). However, only 2.3 percent of all patients were reported accepted for such free care.

#### Hospital Rates—New York State (Exclusive of New York City)

The questionnaire form supplied to hospitals outside of New York City requested in addition information concerning:

The rate paid by the public welfare departments to the hospitals for their accepted charges.

Whether the public welfare departments paid for extras such as: operating room, anesthesia, laboratory service and x-rays, etc. in addition to the standard per diem rate.

Whether the public welfare departments had special arrangements with the hospitals for the care of obstetrical patients.

The per diem rate for paying ward patients varied from \$2.25 to \$5. The majority of the hospitals had rates included in the range from \$3 to \$4 per day. All but two hospitals made additional charges for extra services.

The per diem charges made to departments of public welfare for the care of patients accepted as public responsibilities fell in approximately the same range as the charges for paying patients.

An analysis of the relation of the charges made by each of the 63 hospitals to departments of welfare and to paying ward patients revealed: at 24 hospitals the daily ward rate was the same for department of welfare patients as for paying ward patients. Twenty-three of these hospitals made additional charges for extra services to paying ward patients but only 19 of them made additional charges to departments of public welfare for extra services to relief recipients.

Nineteen of the hospitals charged the welfare departments a higher per diem rate than the rate charged to paying patients; however, 11 of these hospitals did not make additional charge for extra services to welfare clients although these extra charges were made routinely to paying ward patients.



Eleven hospitals charged the welfare departments a lower per diem ward rate than the rate charged to paying ward patients. Despite the policy of making extra charges to paying ward patients, only eight of these hospitals charged departments of public welfare for extra services.

A review of hospital statements regarding specific extra charges made to welfare departments showed a diversity of practice and extreme variations in charges for the specific extra services. Twenty-six hospitals among the 63 studied had special arrangements with departments of public welfare for the payment of hospital care for obstetrical patients. Seven of these hospitals charged a flat rate for periods of 10 or 14 days' hospitalization.

### Hospital Ward Patients—New York City

Table 89 shows the member hospitals (excluding public hospitals) of the Greater New York Hospital Association canvassed for the pay status study classified by size of hospital and ward bed capacity. Seventy-nine hospitals with a total of 12,840 ward beds were canvassed. Eliminating the special and institutional hospitals there remained a total of 60 general hospitals maintaining 10,183 ward beds. Only 5 hospitals with a total ward capacity of 382 beds failed to reply to the questionnaire. Fifteen hospitals with a combined capacity of 2,023 ward beds answered the questionnaire but the data could not be included in this study because it was incomplete or internally inconsistent.

For the present analysis the completed schedules of 40 hospitals with a total ward bed capacity of 7,778 were used. Table 89 shows that this sample represented a higher proportion of the larger hospitals. Most of the hospitals from which replies were not received or were not tabulated had less than 200 beds.

Data from these 40 hospitals with their 7,778 ward beds covered a total of 12,652 ward patients cared for during the month of November, 1939. Table 90a presents composite figures consisting of a summation of each of the items for all the hospitals considered.

Of the 12,652 ward patients, 12.3 percent (see Table 90c) were reported as recipients of public relief, 5.6 percent were supported through WPA wages. Ten thousand three hundred and eighty-seven or 82.1 percent of all patients received income from neither of these public sources. Among these 36.6 percent were referred to the Department of Hospitals for authorization of hospitalization at public expense.

Forty-one percent of all ward patients were expected to pay toward the cost of their hospitalization (see Table 90c). Seventy-four percent of these were expected to pay full ward rates (see Table 90d). Forty and six-tenths percent of all the patients were referred to the Department of Hospitals (see Table 90c). Sixty and seven-tenths percent of those referred had been accepted as public charges by the time the schedules were returned (see Table 90e). The hospitals accepted 17.5 percent of all ward patients for

free care (see Table 90c). Only 0.9 percent were reported as having pay status undetermined by the hospitals.

Twenty-two and four-tenths percent of the 1,475 patients reported as not receiving public relief or WPA wages and not referred or accepted as public charges to receive hospital care were accepted for free care by the hospitals (see Table 90c). Seventy-six and two-tenths percent of the same group were expected to contribute toward the cost of their hospitalization (see Table 90c), three-quarters of whom later were expected to pay full ward rates (see Table 90d).

On the other hand, of the 1,557 already receiving public relief, 1.9 percent (29) were reported as expected to contribute something toward the cost of their hospitalization (see Table 90c). The charges for 65.4 percent of the relief recipient group were referred to the Department of Hospitals. It is of interest that 32.6 percent or only 509 of the relief recipients who might have been expected to become public charges for their hospital costs were given free care by voluntary hospitals with the assistance of community hospital funds.

Of the patients receiving WPA wages, 4.4 percent were expected to meet at least part of their hospital charges (see Table 90c) and 77.4 percent were referred to the Department of Hospitals for authorization for hospital care at public expense and 18.2 percent of the group were given free care by the hospitals.

Of the group that was receiving neither public relief nor WPA wages and had been referred to the Department of Hospitals, 55.7 percent were already accepted as public charges for hospital care at the time of reporting. In the same category of patients 6.3 percent had been refused and distributed among the other four pay status categories in Table 90c and 38 percent were still pending decision by the Department of Hospitals at the time of reporting. Of the 238 patients refused authorization by the Department of Hospitals, 49.2 percent were considered capable of paying toward their hospitalization costs and 44.5 percent were given free care by the voluntary hospitals. The pay status of the remaining cases had not been determined by the hospitals at the time of reporting.

The group of self-supporting patients not receiving public relief nor WPA wages and not referred nor accepted as public charges to receive hospital care comprised 98.4 percent of the group of patients expected to pay the full ward rate and 91.4 percent of the patients expected to pay partial ward rates (see Table 90b). It is not known how many of these self-supporting patients carried hospital care insurance.

Sixty-eight percent of the group accepted as public charges had neither WPA nor relief status (see Table 90b).

The relatively low proportion of relief and WPA patients accepted for hospitalization at public expense in voluntary hospitals may be accounted for by the existence of the large number of ward beds operated by the Department of Hospitals. It may be assumed that the majority of relief recipients were cared for in public hospitals.

It is of interest that 71.3 percent of the patients given free care by the voluntary hospitals were receiving neither public relief nor WPA wages (see Table 90b). This confirms the impression that relief recipients in New York City having access to public hospitals are less of a burden to voluntary hospitals than the non-relief group unable to provide medical care from its own resources.

### Hospital Rates in New York City

In New York City additional information was requested (see Appendix K) from the hospitals canvassed concerning:

The per diem rate charged to paying ward patients;  
Additional charges for extra services.

At the 40 hospitals used in this study the per diem rate for paying ward patients varied from \$2.50 to \$4.50. The majority of charges fell in the \$3 to \$4 range. All but one of these 40 hospitals reported that they made additional charges to patients for extra services.

### Summary of Hospital Data

A study of the pay status of ward patients classified by relief, WPA and non-relief income source groups involved 7,208 ward patients at 63 general hospitals in upstate New York and 12,652 ward patients at 40 general hospitals in New York City.

The study covered all ward patients treated at these hospitals during the month of November, 1939.

The upstate hospitals studied consisted of 55 voluntary, 1 proprietary and 7 public hospitals. All of the 40 New York City hospitals in the study were under voluntary control. The Department of Hospitals of New York City maintains a large number of municipal general hospital beds for the care of the needy and in addition reimburse voluntary and private hospitals for the care of the needy. The municipal hospital system was not included in the survey. Therefore the data from the hospitals studied in upstate New York and from New York City are not strictly comparable. However, the following observations may be made if this reservation is kept in mind.

1. The income source groups represented in the ward patients at the upstate hospitals studied consisted of 33.7 percent relief, 4.5 percent WPA and 61.8 percent without income from these two sources. The group of New York City patients was made up of 12.3 percent relief, 5.6 percent WPA and 82.1 percent without relief or WPA status.

2. Of the total upstate ward patients studied 50.5 percent were expected to contribute toward the cost of their hospitalization, while in the New York City group of patients this figure was 41.0 percent.



3. Forty-four percent of all the ward patients in upstate hospitals were referred to departments of welfare for authorization of their hospital charges as a public expenditure while 40.6 percent of the patients in New York City voluntary hospitals were referred to the Department of Hospitals for the same purpose. However, the upstate New York group referred to departments of welfare included 72.8 percent who were relief recipients. Patients who were receiving neither relief nor WPA wages made up 18.8 percent. In New York City the group referred by voluntary hospitals to the Department of Hospitals contained over 19.8 per cent relief recipients, whereas, 69.5 percent received neither relief nor WPA wages.

4. Free care was given by the voluntary hospitals to 2.3 percent of all ward patients in the upstate New York survey in contrast to 17.5 percent of all ward patients in the New York City group.

5. Less than 2 percent of the relief recipients were given free care by the voluntary hospitals in upstate New York. In New York City almost one-third of all relief patients admitted received free care from voluntary hospitals.

6. Among ward patients studied who received income from neither relief nor WPA wages 13.4 percent were referred to public welfare departments in upstate New York while in New York City 36.6 percent of the patients in this income category were referred to the Department of Hospitals for approval of public assumption of hospital charges.

7. Among all ward patients expected to pay toward the cost of their hospitalization a higher proportion were expected to pay the full ward rates in upstate New York than in New York City.

#### Analysis of Clinic Data (See Appendices J and K on pages 468; 472)

Data were requested from the canvassed hospitals in both New York City and upstate New York regarding:

Total number and disposition of applications for clinic care during November, 1939.

The pay status of patients of each income source group accepted for clinic care.

Number of patients refused clinic care and reasons for rejection.

The number of patient clinic visits made classified by pay status.

Responsibility for payment for prescriptions, appliances and special services.

Schedules for obtaining these clinic data from both upstate and New York City hospitals were prepared. They differed in that the upstate form called for a breakdown of the clinic admission fees into:

Patient paying full clinic charges.

Patient paying partial clinic charges.

Clinic fee paid from public welfare funds.

Free care.



The New York City schedule contained only the two categories:

Patient paying full clinic admission fees.

Free care.

The New York City Department of Hospitals maintains a system of public clinics to serve needy patients and does not reimburse voluntary or private hospitals for out-patient services.

#### Clinic Patients—New York State (Exclusive of New York City)

The composite picture of the pay status of out-patient department patients for upstate New York during the month of November, 1939, is based on reports from 12 voluntary hospitals. Reports were received from 32 clinics maintained by general hospitals canvassed in this study. Because of incomplete or inconsistent data 20 of the clinic reports could not be used in the present tabulation.

A large number of the hospitals in upstate New York, especially those serving smaller communities, do not maintain out-patient departments.

During the month of November, 1939, the 12 clinics included in our compilation reported a total of 11,148 visits (see Table 91a). Five thousand three hundred and twenty-nine individuals applied for clinic care at the clinics included in this study and 110 (2.1 percent) of the applicants were refused clinic admission (see Table 91c). The most frequent reason given for refusal was the determination that the patient was able to afford a private physician's services. This accounted for 36.4 percent of all rejections (see Table 91d). In 24.5 percent of the rejected cases the patients were found to be already under the care of another clinic. Lack of facilities was the reason stated for 21.8 percent of the rejections.

Of the 5,219 accepted cases 41.8 percent were receiving public relief and 9.0 percent were WPA workers, and the remaining 49.2 percent were not receiving relief or WPA wages (see Table 92b).

Thirty and two-tenths percent of all patients at voluntary hospital clinics were expected to pay a full or partial clinic fee (see Table 92c). Sixty-six and eight-tenths percent received free care and clinic fees were paid from public funds in only 3 percent of cases (see Table 92c).

Among the non-relief, non-WPA patients 52.4 percent were expected to pay clinic fees and 47.6 percent were treated free of charge (see Table 92c). Among patients receiving public relief, only 6.2 percent were expected to pay clinic fees. Public welfare agencies assumed the charge for only 6.7 percent of relief recipients. The remaining 87.1 percent of relief clients received free care at the clinics of these voluntary hospitals (see Table 92c).

Eighty-six and eight-tenths percent of the patients who paid full clinic fees were not receiving income from relief or WPA sources. On the other hand 94.2 percent of the 155 patients for whom public welfare agencies paid clinics fees were relief recipients

(see Table 92b). More than 50 percent of the patients who received free clinic care from the out-patient departments of these upstate voluntary hospitals were persons receiving public relief (see Table 92b).

A total of 11,148 clinic visits were reported by the clinics studied. Twenty and nine-tenths percent of these visits were paid for in full, 3.5 percent in part, and 72.3 percent were given free of charge by these voluntary hospital clinics. Only 3.3 percent of the clinic visits were paid for from public funds (see Table 91a).

A summary of the method and extent of payment for prescriptions, appliances and special services at the hospital clinics under study during the month of November, 1939, showed that 81.4 percent of the patients receiving these medical supplies and services got them free from the clinics. Public welfare agencies paid the clinics for these supplies and services for only 1.9 percent of the patients. The remaining 16.7 percent of the patients paid in full or in part for these extra charges (see Table 91b).

### Clinic Patients—New York City

The clinic reports submitted by 21 New York City voluntary hospitals concerning patients treated at their out-patient departments during November, 1939, were tabulated and summarized. Clinic reports were received from 30 additional general hospitals. These additional reports were found to contain incomplete or internally inconsistent data and were considered unsuitable for this tabulation.

The 21 hospitals tabulated reported 32,124 applications for clinic care within the month of study, of which 28,804 (89.7 percent) were accepted for care by the clinics (see Tables 93a and 93c). One-tenth of all patients applying for clinic care were rejected. An analysis of the reasons for rejecting these patients showed that 33.7 percent of the rejected patients were referred to clinics at public hospitals, 17.4 percent were referred to clinics of other voluntary hospitals and 7.4 percent were found to be already under care in other clinics. Twenty-one and six-tenths percent were refused because it was determined that they could afford private physicians (see Table 93d).

The 28,804 clinic patients accepted for care consisted of 18.1 percent relief recipients, 6.3 percent WPA workers and 75.6 percent who received support or income from other sources (see Table 94b).

Sixty and eight-tenths percent of all applicants paid full clinic fees and 39.2 percent received free care from the hospitals. Of the non-relief, non-WPA group, 76.2 percent paid full clinic fees while among the relief recipients only 7.6 percent and among the WPA group 27.9 percent paid in full (see Table 94c).

Ninety-four and eight-tenths percent of the patients who paid at the full rate were not relief clients or WPA workers (see Table

94b). Only 45.8 percent of those receiving free care were to be found among this income source group.

During the month under study the reporting clinics had a total of 162,204 patient visits. Fifty-three and three-tenths percent of these visits were given free of charge and the remaining 46.7 percent were paid for by patients (see Table 93a).

Forty-five thousand eight hundred and thirty-three patients received prescriptions, appliances and special services at the clinics studied during this period. Forty-two and nine-tenths percent of the patients received these services free of charge from the hospitals. The Department of Welfare paid for these supplies and services for 18.6 percent of the patients who received them. Thirty-eight and five-tenths percent of the patients contributed toward the cost of extra services (see Table 93b).

### Summary of Clinic Data

The study of pay status and income source of patients seeking care during November, 1939, at the out-patient clinics of voluntary hospitals covered 12 upstate hospitals and 21 New York City hospitals.

The upstate hospital clinics reported on 11,148 visits and 5,329 applicants. The New York City hospitals covered 162,204 visits and 32,124 applicants.

Although hospital clinics in both upstate New York and New York City were those of voluntary hospitals, the two groups are not exactly comparable because in New York City there are a large number of free clinics operated by the Department of Hospitals. In the upstate area free clinics operated by public hospitals exist in some places but in general have not been developed as extensively as in New York City.

1. The upstate New York clinics rejected only 2.1 percent of the patients who applied for care while in New York City 10.2 percent were rejected, but more than half of these were rejected because they had been referred to or were under the care of other clinics.

2. One-half of the patients accepted for care at the upstate clinics during November, 1939, were recipients of relief or WPA wages, whereas these groups accounted for only one-quarter of the patients accepted by the New York City voluntary hospital clinics.

3. Sixty-seven percent of all patients accepted by the surveyed upstate clinics during November, 1939, received free care from these voluntary hospital clinics in contrast to the 40 percent in New York City. On the basis of total visits, 72.3 percent were given free by the hospitals studied in upstate New York and 53.3 percent in New York City.

4. At the upstate hospital clinics studied only 30.2 percent of the cases accepted for clinic care in November, 1939, paid clinic fees while 60.8 percent paid clinic fees in New York City.



5. Among new patients receiving neither relief nor WPA income 52.4 percent paid clinic fees at the upstate New York clinics studied while in New York City 76.2 percent of this income group paid clinic fees.

6. Public welfare funds paid for only 3 percent of accepted clinic patients and 3.3 percent of total clinic visits at the voluntary hospital out-patient departments surveyed in upstate New York during November, 1939. As a matter of policy New York City does not reimburse voluntary hospital clinics because it operates a municipal system of clinics.

7. Eighty-one and four-tenths percent of the clinic patients receiving prescriptions, appliances and special services were given these supplies and services free of charge by the voluntary hospital clinics studied in upstate New York while in New York City 42.9 percent of patients received these supplies and services free. Public welfare funds paid for these supplies and services for only 1.9 percent of the patients receiving them in upstate New York in contrast to 18.6 percent paid for by the Welfare Department in New York City.



TABLE 87  
New York State (Exclusive of New York City)  
Pay Status of Patients in Hospital Wards, November, 1939  
MEMBER HOSPITALS OF HOSPITAL ASSOCIATION OF NEW YORK STATE, CLASSIFIED BY  
TYPE OF CONTROL AND SIZE OF HOSPITAL

	HOSPITALS BY TYPE OF CONTROL				Total ward beds <sup>1</sup>	HOSPITALS BY SIZE OF HOSPITAL <sup>2</sup>										
	Total hospitals	Voluntary				Public	LESS THAN 50 BED				50-99 BED		100-199 BED		200 BED AND OVER	
		(2)	(3)	(4)			No. of hospitals	No. of ward beds	(8)	(9)	(10)	(11)	No. of hospitals	No. of ward beds		
(1)					(5)	(6)	(7)	(8)	(9)	(10)	(11)	(12)	(13)			
Total hospital members of Hospital Association of New York State, exclusive of New York City hospitals.....	170	138	6	26	8,374	36	358	56	1,284	53	3,027	25	3,705			
Special and institutional hospitals.....	26	17	1	8	667	7 <sup>a</sup>	59	7 <sup>b</sup>	180	6 <sup>d</sup>	129	6 <sup>c</sup>	299			
General hospitals.....	144	121	5	18	7,707	29	299	49	1,104	47	2,898	19	3,406			
General hospitals not replying to questionnaire by February 10, 1940.	37	28	2	7	2,425	7 <sup>d</sup>	17	15	339	12	765	3	1,304			
General hospitals replying to questionnaire.....	107	93	3	11	5,282	22	282	34	765	35	2,133	16	2,102			
General hospitals considered in this study.....	63	55	1	7	3,069	14 <sup>e</sup>	238	17 <sup>d</sup>	328	23	1,326	9 <sup>f</sup>	1,177			
General hospitals not considered in this study <sup>3</sup> .....	44	38	2	4	2,213	8 <sup>g</sup>	44	17 <sup>h</sup>	437	12	807	7 <sup>i</sup>	925			

<sup>1</sup> Beds and cribs in rooms with 5 or more beds or cribs, reported as of Dec. 31, 1938, to the New York State Dept. of Social Welfare. <sup>2</sup> Based on total beds as reported in the Hospital Number, Jour. A.M.A., Vol. 112, No. 8, March 11, 1939. <sup>3</sup> Consists of 18 hospitals submitting incomplete reports and 26 hospitals submitting inconsistent reports. <sup>4</sup> Includes 1 hospital reporting no ward beds and 1 hospital not reporting. <sup>5</sup> Includes 1 hospital reporting no ward beds and 2 hospitals not reporting. <sup>6</sup> Includes 2 hospitals reporting no ward beds and 2 hospitals not reporting. <sup>7</sup> Includes 5 hospitals reporting no ward beds. <sup>8</sup> Includes 3 hospitals reporting no ward beds. <sup>9</sup> Includes 1 hospital reporting no ward beds. <sup>10</sup> Includes 4 hospitals reporting no ward beds. <sup>11</sup> Includes 2 hospitals reporting no ward beds.

TABLE 88

New York State (Exclusive of New York City)  
Pay Status of Patients in Hospital Wards, November, 1939  
WARD PATIENTS AT 63 GENERAL HOSPITALS CLASSIFIED BY  
RESPONSIBILITY FOR PAYMENT OF HOSPITAL CHARGES  
AND BY SOURCE OF INCOME

Responsibility for payment	Total	Receiving public relief other than medical or hospital care	Receiving WPA wages	Not receiving public relief nor WPA wages
<b>a. Distribution of patients</b>				
Total.....	7,208	2,432	322	4,454
Expected to pay.....	3,638	41	48	3,549
Full ward rate.....	3,111	40	27	3,044
Partial ward rate.....	527	1	21	505
Referred to Department of Public Welfare.....	3,173	2,310	268	595
Accepted.....	2,646	2,029	218	399
Decision pending.....	527	281	50	196
Free care by hospital.....	168	41	.....	127
Status not determined.....	229	40	6	183
<b>b. Percent distribution of patients by source of income</b>				
Total.....	100.0	33.7	4.5	61.8
Expected to pay.....	100.0	1.1	1.3	97.6
Full ward rate.....	100.0	1.3	0.9	97.8
Partial ward rate.....	100.0	0.2	4.0	95.8
Referred to Department of Public Welfare.....	100.0	72.8	8.4	18.8
Accepted.....	100.0	76.7	8.2	15.1
Decision pending.....	100.0	53.3	9.5	37.2
Free care by hospital.....	100.0	24.4	.....	75.6
Status not determined.....	100.0	17.5	2.6	79.9
<b>c. Percent distribution of patients by responsibility for payment</b>				
Total.....	100.0	100.0	100.0	100.0
Expected to pay.....	50.5	1.7	14.9	79.7
Full ward rate.....	43.2	1.7	8.4	68.3
Partial ward rate.....	7.3	*	6.5	11.4
Referred to Department of Public Welfare.....	44.0	95.0	33.2	13.4
Accepted.....	36.7	83.4	67.7	9.0
Decision pending.....	7.3	11.6	15.5	4.4
Free care by hospital.....	2.3	1.7	.....	2.8
Status not determined.....	3.2	1.6	1.9	4.1
<b>d. Percent distribution of patients expected to pay by extent of payment</b>				
Expected to pay.....	100.0	100.0	100.0	100.0
Full ward rate.....	85.5	97.6	56.3	85.8
Partial ward rate.....	14.5	2.4	43.7	14.2
<b>e. Percent distribution of patients referred to Department of Public Welfare by disposition</b>				
Referred to Department of Public Welfare.....	100.0	100.0	100.0	100.0
Accepted.....	83.4	87.8	81.3	67.1
Decision pending.....	16.6	12.2	18.7	32.9

\* Less than 0.1 percent.

TABLE 89  
New York City  
Pay Status of Patients in Hospital Wards, November, 1939  
MEMBER HOSPITALS OF GREATER NEW YORK HOSPITAL ASSOCIATION, EXCLUSIVE OF PUBLIC HOSPITALS,  
CLASSIFIED BY SIZE OF HOSPITAL

HOSPITALS BY SIZE OF HOSPITAL <sup>2</sup>														
Total hospitals	Total ward <sup>1</sup> beds	LESS THAN 100 BED		100-199 BED		200-299 BED		300-399 BED		400-499 BED		500 BED AND OVER		
		No. of hospitals	No. of ward beds	No. of hospitals	No. of ward beds	No. of hospitals	No. of ward beds	No. of hospitals	No. of ward beds	No. of hospitals	No. of ward beds	No. of hospitals	No. of ward beds	
(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)	(12)	(13)	(14)	
Total hospital members of Greater New York Hospital Association, exclusive of public hospitals.....	79	12,840	10	338	26	2,197	20	2,860	11	2,073	5	1,597	7	3,775
Special and institutional hospitals.....	19	2,657	5*	138	4	457	6	948	2	246	1	343	1	525
General hospitals.....	60	10,183	5	200	22	1,740	14	1,912	9	1,827	4	1,254	6	3,250
General hospitals not replying to questionnaire by February 10, 1940.....	5 <sup>b</sup>	382	1	53	3	199	1	130	.....	.....	.....	.....	.....	.....
General hospitals replying to questionnaire.....	55	9,801	4	147	19	1,541	13	1,782	9	1,827	4	1,254	6	3,250
General hospitals considered in this study.....	40	7,778	2	81	13	1,189	12	1,569	5	1,055	2	634	6	3,250
General hospitals not considered in this study <sup>a</sup> .....	15	2,023	2	66	6	352	1	213	4	772	2	620	.....	.....

<sup>1</sup> Beds and cribs in rooms with 5 or more beds or cribs, reported as of December 31, 1938, to the New York State Department of Social Welfare.

<sup>2</sup> Based on total beds as reported the Hospital Number, Jour. A. M. A., Vol. 112, No. 8, March 11, 1939.

<sup>3</sup> Consists of 11 hospitals which submitted incomplete reports and 4 hospitals which submitted a report containing inconsistent data.

<sup>a</sup> Includes 1 institution reporting as a medical convalescent home.

<sup>b</sup> Includes 1 proprietary hospital.

TABLE 90  
New York CityPay Status of Patients in Hospital Wards, November, 1939  
WARD PATIENTS AT 40 GENERAL HOSPITALS CLASSIFIED BY  
RESPONSIBILITY FOR PAYMENT OF HOSPITAL CHARGES  
AND BY SOURCE OF INCOME

RESPONSIBILITY FOR PAYMENT	SOURCE OF INCOME				
	Total	Receiving public relief	Receiving WPA wages	Not receiving public relief nor WPA wages but referred or accepted as public charges to receive hospital care	Not receiving public relief nor WPA wages and not referred nor accepted as public charges to receive hospital care
a. Distribution of patients					
Total.....	12,652	1,557	708	3,806	6,581
Expected to pay.....	5,190	29	31	117	5,013
Full ward rate.....	3,841	6	16	39	3,780
Partial ward rate.....	1,349	23	15	78	1,233
Referred to Department of Hospitals.....	5,134	1,018	548	3,568	.....
Accepted.....	3,116	672	324	2,120	.....
Decision pending.....	2,018	346	224	1,448	.....
Free care by hospital.....	2,219	509	129	106	1,475
Status not determined.....	109	1	.....	15	93
b. Percent distribution of patients by source of income					
Total.....	100.0	12.3	5.6	30.1	52.0
Expected to pay.....	100.0	0.6	0.6	2.2	96.6
Full ward rate.....	100.0	0.2	0.4	1.0	98.4
Partial ward rate.....	100.0	1.7	1.1	5.8	91.4
Referred to Department of Hospitals.....	100.0	19.8	10.7	69.5	.....
Accepted.....	100.0	21.6	10.4	68.0	.....
Decision pending.....	100.0	17.1	11.1	71.8	.....
Free care by hospital.....	100.0	22.9	5.8	4.8	66.5
Status not determined.....	100.0	0.9	.....	13.8	85.3
c. Percent distribution of patients by responsibility for payment					
Total.....	100.0	100.0	100.0	100.0	100.0
Expected to pay.....	41.0	1.9	4.4	3.1 <sup>a</sup>	76.2
Full ward rate.....	30.4	0.4	2.3	1.0 <sup>a</sup>	57.4
Partial ward rate.....	10.6	1.5	2.1	2.1 <sup>a</sup>	18.8
Referred to Department of Hospitals.....	40.6	65.4	77.4	93.7	.....
Accepted.....	24.6	43.2	45.8	55.7	.....
Decision pending.....	16.0	22.2	31.6	38.0	.....
Free care by hospital.....	17.5	32.6	18.2	2.8 <sup>a</sup>	22.4
Status not determined.....	0.9	0.1	.....	0.4 <sup>a</sup>	1.4
d. Percent distribution of patients expected to pay by extent of payment					
Expected to pay.....	100.0	100.0	100.0	100.0	100.0
Full ward rate.....	74.0	20.7	51.6	33.3	75.4
Partial ward rate.....	26.0	79.3	48.4	66.7	24.6
e. Percent distribution of patients referred to Department of Hospitals by disposition					
Referred to Department of Hospitals.....	100.0	100.0	100.0	100.0	.....
Accepted.....	60.7	66.0	59.1	59.4	.....
Decision pending.....	39.3	34.0	40.9	40.6	.....

<sup>a</sup> Charges already referred by Department of Hospitals and subsequently disposed of in other ways.



TABLE 91

New York State (Exclusive of New York City)  
 Pay Status of Patients in Hospital Clinics, November, 1939  
 CLINIC PATIENTS AT 12 VOLUNTARY HOSPITALS CLASSIFIED BY  
 RESPONSIBILITY FOR PAYMENT AND BY DISPOSITION  
 OF APPLICATIONS

## a. Visits to hospital clinics classified by responsibility for payment

SOURCE OF PAYMENT	Number of visits	Percent of visits
Total visits.....	11,148	100.0
Full payment of clinic admission fees by patient.....	2,329	20.9
Partial payment of clinic admission fees by patient.....	391	3.5
Clinic fee paid from public funds.....	365	3.3
Free care.....	8,063	72.3

## b. Patients receiving prescriptions, appliances and other services classified by responsibility for payment

SOURCE OF PAYMENT	Number of patients	Percent of patients
Total patients.....	2,569	100.0
Full payment by patient.....	339	13.2
Partial payment by patient.....	91	3.5
Welfare department payment.....	49	1.9
Given entirely free.....	2,090	81.4

## c. Applications for clinic care classified by disposition

DISPOSITION OF CASES	Number of applications	Percent of applications
Total applications.....	5,329	100.0
New cases accepted for care during November (new cases and old cases reapplying).....	5,219	97.9
Cases rejected during November.....	110	2.1
Cases undecided on November 30.....		

## d. Cases rejected for clinic care classified by reason for rejection

REASON FOR REJECTION	Number of rejections	Percent of rejections
Total rejections.....	110	100.0
Patient can afford private physician.....	40	36.4
Private physician will treat free or give credit.....	7	6.4
Already under care in another clinic.....	27	24.5
Clinic care not needed.....	1	0.9
Referred to other clinic (private).....		
Referred to other clinic (public).....	4	3.6
Lack of facilities.....	24	21.8
Other.....	7	6.4

TABLE 92

New York State (Exclusive of New York City)

Pay Stat us of Patients in Hospital Clinics, November, 1939

CLINIC PATIENTS AT 12 VOLUNTARY HOSPITALS CLASSIFIED BY  
RESPONSIBILITY FOR PAYMENT AND BY SOURCE OF INCOME

PAYMENT OF CLINIC ADMISSION FEES	Total	Receiving public relief	On WPA wages	Not receiving public relief or WPA
a. Cases accepted for clinic care classified by responsibility for payment of clinic admission fees and by source of income				
Total accepted cases.....	5,219	2,182	470	2,567
Patient paid full clinic charges.....	1,436	115	75	1,246
Patient paid partial clinic charges.....	144	20	25	99
Clinic fee paid from public welfare funds.....	155	146	9	.....
Free care.....	3,484	1,901	361	1,222
b. Percent distribution of accepted cases by source of income				
Total.....	100.0	41.8	9.0	49.2
Patient paid full clinic charges.....	100.0	8.0	5.2	86.8
Patient paid partial clinic charges.....	100.0	13.9	17.4	68.7
Clinic fee paid from public welfare funds.....	100.0	94.2	5.8	.....
Free care.....	100.0	54.6	10.4	35.0
c. Percent distribution of accepted cases by responsibility for payment				
Total.....	100.0	100.0	100.0	100.0
Patient paid full clinic charges.....	27.5	5.3	16.0	48.5
Patient paid partial clinic charges.....	2.7	0.9	5.3	3.9
Clinic fee paid from public welfare funds.....	3.0	6.7	1.9	.....
Free care.....	66.8	87.1	76.8	47.6

TABLE 93  
New York City  
Pay Status of Patients in Hospital Clinics, November, 1939  
CLINIC PATIENTS AT 21 VOLUNTARY HOSPITALS CLASSIFIED BY  
RESPONSIBILITY FOR PAYMENT AND BY DISPOSITION  
OF APPLICATIONS

a. Visits to hospital clinics classified by responsibility for payment

SOURCE OF PAYMENT	Number of visits	Percent of visits
Total visits.....	162,204	100.0
Full payment of clinic admission fees by patient.....	75,772	46.7
Free care.....	86,432	53.3

b. Patients receiving prescriptions, appliances and other services classified by responsibility for payment

SOURCE OF PAYMENT	Number of patients	Percent of patients
Total patients.....	45,833	100.0
Full payment by patient.....	15,212	33.2
Partial payment by patient.....	2,456	5.3
Welfare department payment.....	8,519	18.6
Given entirely free.....	19,646	42.9

c. Applications for clinic care classified by disposition

DISPOSITION OF CASES	Number of applications	Percent of applications
Total applications.....	32,124	100.0
New cases accepted for care during November (new cases and old cases reapplying).....	28,804	89.7
Cases rejected during November.....	3,271	10.2
Cases undecided on November 30.....	49	0.1

d. Cases rejected for clinic care classified by reason for rejection

REASON FOR REJECTION	Number of rejections	Percent of rejections
Total rejections.....	3,271	100.0
Patient can afford private physician.....	706	21.6
Private physician will treat free or give credit.....	16	0.5
Clinic care not needed.....	48	1.5
Already under care in another clinic.....	242	7.4
Referred to other clinic (private).....	569	17.4
Referred to other clinic (public).....	1,103	33.7
Lack of facilities.....	88	2.7
Other.....	499	15.2

TABLE 94

New York City

Pay Status of Patients in Hospital Clinics, November, 1939

CLINIC PATIENTS AT 21 VOLUNTARY HOSPITALS CLASSIFIED BY  
RESPONSIBILITY FOR PAYMENT AND BY SOURCE OF INCOME

PAYMENT OF CLINIC ADMISSION FEES	Total	Receiving public relief	On WPA wages	Not receiving public relief or WPA
a. Cases accepted for clinic care classified by responsibility for payment of clinic admission fees and by source of income				
Total accepted cases.....	28,804	5,203	1,821	21,780
Patient paid full clinic charges.....	17,507	395	508	16,604
Free care.....	11,297	4,808	1,313	5,176
b. Percent distribution of accepted cases by source of income				
Total.....	100.0	18.1	6.3	75.6
Patients paid full clinic charges.....	100.0	2.3	2.9	94.8
Free care.....	100.0	42.6	11.6	45.8
c. Percent distribution of accepted cases by responsibility for payment				
Total.....	100.0	100.0	100.0	100.0
Patient paid full clinic charges.....	60.8	7.6	27.9	76.2
Free care.....	39.2	92.4	72.1	23.8





## Chapter V

### GRADUATE MEDICAL EDUCATION IN NEW YORK STATE

#### Introduction

The Commission has considered the problems of graduate medical education within its scope because physicians schooled and experienced in modern scientific methods are essential to the fullest possible development of preventive and curative medicine. The opportunity that is provided young men and women about to enter the field of medical practice to acquire modern skills and techniques under adequate supervision is a matter of public concern.

Both the public and the medical practice of the future would benefit if every young medical graduate could have a hospital experience which is truly educational. Recent accomplishments in the control of such diseases as pneumonia and syphilis have demonstrated that the application of newly developed procedures can materially lower death rates and costs of illness. For the young physician, supervised instruction in the hospital offers an excellent opportunity to acquire a practical knowledge of these new procedures.

A study committee on medical standards appointed by the Chairman of the Commission was requested to investigate the problems of graduate medical education, as well as a practical method for voluntary certification of medical specialists. The work of this committee in relation to medical education during the last year included consultations with medical educators, a conference with representatives of the medical groups interested, study of State medical practice acts, and special surveys.

A study of the recent history of medical education and consultations, both by means of conferences and correspondence with medical educators, showed that this group recognized the intern year as an essential part of the educational preparation for the practice of medicine.

In 1915 some schools of medicine established a requirement of one year of approved intern training for the degree of Doctor of Medicine. By 1939, 13 schools situated in the Southern, Midwestern and Western sections of the United States and four schools in Canada had adopted this requirement.

The legislatures of a number of states, beginning with Pennsylvania in 1914, amended their medical practice acts to require one year of intern training as a prerequisite for medical licensure. By 1939, 21 widely-scattered states, the District of Columbia, Alaska and Porto Rico had enacted similar legislation. These laws were reviewed by the Commission from the point of view of content of the internship required, administrative procedure and difficulties arising in the functioning of these laws. New York State has not

been one of the states requiring intern training for medical licensure.

A survey was made of the existing opportunities for intern training in New York State based on standards formulated by the American Medical Association. A detailed analysis of the data submitted is presented below as Study 1. It was found that 1,347 of the 1,684 approved internships available in New York State were located in New York City. The lack of facilities for intern training in upstate New York is reflected in the fact that only 16.7 percent of the general hospitals (representing 42 percent of all general hospital beds in this area) are approved by the American Medical Association for the training of interns.

The House of Delegates of the Medical Society of the State of New York at a meeting on April 25, 1939, adopted the following resolution:

*"Resolved: That the House of Delegates hereby instructs the officers of the Medical Association of the State of New York to take whatever steps that may be necessary to secure the introduction of legislation to amend the Medical Practice Act so as to require internship of not less than one year in an acceptable hospital approved for internship by the American Medical Association before a license to practice medicine may be granted by the Board of Regents of the University of New York."*<sup>1</sup>

On November 16, 1939, a round table conference was held at the New York City Academy of Medicine by the Committee on Medical Standards of the Commission. This meeting was attended by representatives of the Medical Council of the State of New York, American Medical Association, Medical Society of the State of New York, New York City Academy of Medicine, State Departments of Health, Education and Social Welfare, State Board of Medical Examiners, Greater New York Hospital Association, Hospital Association of New York State, the Hospital Council of Greater New York, the deans of all the medical schools in New York State and members of the Committee on Medical Standards and the technical staff of the Commission.

Two questions were considered at this meeting.

1. Is it advisable to introduce State legislation requiring one year of intern training at a hospital approved for this purpose as a prerequisite for medical licensure? Consideration was given to the adequacy of hospital facilities for intern training, the method of approving hospitals for this purpose, the type of intern requirement desired and the type of educational facilities desirable in a hospital. The group expressed itself in favor of supervised intern training as an essential part of medical education and medical licensure. Representatives of the Association of Medical Colleges and the American Medical Association reported the existence of adequate opportunities for intern training in the United States.

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<sup>1</sup> Minutes of the annual meeting of the House of Delegates, New York State Journal of Medicine, Vol. 39, No. 12, 1939, p. 1234.

Seventeen votes in favor and no opposing votes were recorded for "the additional requirement of a year of internship in a properly qualified hospital before the granting of a license to practice medicine."<sup>2</sup>

2. Is it advisable to establish at the State level a voluntary register of medical specialists? The registration of specialists was endorsed in principle with the recommendation that, for the present, such registration and endorsement of specialists be left with the non-governmental groups active in such work.

Following this meeting the Committee on Medical Standards requested that information be secured regarding the interns and residents serving the hospitals unapproved by the American Medical Association for intern training in New York State (exclusive of New York City). This study was carried out by canvassing the 163 hospitals in upstate New York not approved by the American Medical Association for the training of interns. The study brought to light the fact that there was in New York State a number of physicians receiving intern training in a small proportion of the hospitals in the State not approved for this purpose. Half of these interns were graduates of schools not recognized by the New York State Board of Medical Examiners and would not be eligible for medical licensure in New York State. Further, it was found that very few of the hospitals not approved for intern training had the services of interns. A detailed analysis of the data submitted is presented below as Study 2.

As a result of these studies, two bills were prepared for submission to the State Legislature. One bill was designed to require the completion of a one year internship approved by the Department of Education as a prerequisite for a license to practice medicine in New York State. This bill was recommended to the Legislature by the Commission and was introduced in the Assembly by Mr. Mailler on February 13, 1940, Introductory Number 1420 and in the Senate by Mr. Mahoney on February 27, 1940, Introductory Number 1158.<sup>3</sup> The text of this bill is in Appendix L, page 476.

The second bill, designed primarily to protect the public, called for changes in the Medical Practice Act which would prohibit the appointment of graduates of unaccredited medical schools as interns or residents in hospitals in New York State. This bill was recommended to the Legislature by the Commission and introduced in the Assembly by Miss Todd on March 8, 1940, Assembly Introductory Number 2158 and in the Senate by Mr. Mahoney on March 19, 1940, as Senate Introductory Number 1685.<sup>4</sup>

In order to estimate the number of candidates for medical licensure in New York State likely to be affected each year by the pro-

<sup>2</sup> Proceedings of Meeting, November 16, 1939, of Committee on Medical Standards of the Temporary Legislative Commission to Formulate a Long Range State Health Program, p. 51.

<sup>3</sup> This bill was passed by the 1940 Legislature and vetoed by the Governor.

<sup>4</sup> For text see Appendix M, page 479. This became law April 26, 1940. (Chap. 761, Laws of 1940.)



posed intern requirement legislation, the American Medical Association was asked to cooperate by supplying data on the intern experience of physicians licensed to practice in New York State during the five year period 1933-38.

A preliminary analysis of this data for the years 1937 and 1938 (see Study 3) showed the majority of physicians not recorded as having completed at least one year of approved intern training were graduates of foreign medical schools.

This study also revealed that during these two years 23 graduates of unaccredited schools obtained licenses to practice medicine in New York State by endorsement of credentials from other states. This situation indicated the need for immediate correction.

### Study 1: Opportunities for Intern Training in New York State

A study was made to determine the extent to which the general hospitals in New York State offer an opportunity for the training of interns.

The list of general hospitals approved by the Council on Medical Education and Hospitals of the American Medical Association for the training of interns<sup>5</sup> was used as the source of information for this study as it is the most widely accepted standard list. The American Medical Association has long been active in increasing the educational value of hospitals by formulation of standards and approval of hospitals for intern training.

For each of the hospitals in New York State on the approved list the number of hospital beds, number of internships available and type of control was obtained. Summary tables showing the entire State, upstate New York and New York City were prepared. (See Table 95.)

One hundred and two hospitals are approved for intern training in New York State. The total bed capacity of these hospitals is 41,870. This group of hospitals offers intern appointments to 1,684 medical graduates.

Only 39 of the 102 hospitals offering internships are located outside of New York City. These upstate hospitals offer only 337 of the 1,684 internships in the State.

The majority of the approved hospitals in the State are under voluntary control (80 among 102). Among the 20 hospitals under public control, 16 are city hospitals. Only two proprietary hospitals are included. Although the public hospitals form only 19.6 percent of all the hospitals they offer 39 percent of the total intern appointments.

The 13 city hospitals in New York City account for 569 or one-third of all the internships in the State.

Information on type of control and number of beds in general hospitals in upstate New York was obtained from the preliminary report of the Commission.<sup>6</sup> The proportion of hospitals approved

<sup>5</sup> Journal of the American Medical Association (Education Number), Aug. 26, 1939, Vol. 113, No. 9, pp. 836-837.

<sup>6</sup> Leg. Doc. (1939) No. 97, pp. 32-35.

for intern training was computed for each type of hospital control. In addition, a similar computation based on bed capacity was prepared. (See Table 96.) It was found that only 16.7 percent of the general hospitals were approved for intern training. This group of hospitals includes 42 percent of the total beds in all general hospitals in the upstate area. Twenty-four and six-tenths percent of all voluntary general hospitals in upstate New York representing 50.8 percent of the upstate voluntary general hospital beds are approved for intern training.

It should be remembered that both Federal and State hospitals maintain full-time paid medical staffs and that many of these general hospital beds are in the infirmaries of government institutions.

### *Conclusions:*

1. The general hospitals of New York City contribute the majority of approved internship opportunities.
2. One-third of all approved internships in New York State are offered by 13 municipal general hospitals of New York City.
3. Only sixteen and seven-tenths percent of the approved general hospitals in upstate New York are approved for the training of interns.
4. Voluntary general hospitals provide most of the opportunities for the training of interns in the upstate area.

### **Study 2: Intern and Resident Staffs in Hospitals not Approved for Intern Training**

A study was made to ascertain the number of physicians receiving intern training in hospitals in upstate New York not approved for this purpose by the Council on Medical Education and Hospitals of the American Medical Association. The Commission wished to have an estimate of the number of these hospitals which would be deprived of the services of interns should the proposed legislation, requiring an approved internship for medical licensure, be adopted. A questionnaire (see Appendix N, pages 481-2, was prepared requesting the following information:

1. Visiting staff policy?
2. Existence and type of attending ward service staff?
3. Existence of, or reason for not having, an intern staff?
4. If an intern staff was maintained:
  - a. Type of intern service?
  - b. Monthly stipend (if any)?
  - c. Number of interns holding appointments at present?
  - d. Medical school, graduation date and previous approved internship (if any) of each intern?
5. Existence of a resident staff?

6. If a resident staff is maintained :

- a. Number of residents holding appointment at present?
- b. Medical school, graduation date and previous approved internship (if any) of each resident?

On December 28, 1939, these schedules were submitted to the superintendents of the 163 general hospitals in upstate New York not on the approved list for the training of interns.<sup>7</sup>

By February 10, 1940, replies had been received from 126 hospitals with a total bed capacity of 8,975. Twenty-one of the replying hospitals, with a capacity of 1,790 beds, were army, veterans', administration, or institutional hospitals and were omitted from the tabulation. The 37 hospitals which had not replied by February 10, 1940, represented a total of 2,672 beds.

The 105 hospitals (containing 7,185 beds) on which the present tabulation was based form a representative sample of the upstate unapproved general hospitals from the standpoint of size and control. (See Table 97.)

*Analysis of Intern and Resident Data.*—Of the 105 hospitals studied, 69 were without interns or residents, 11 had interns but no residents, 2 had both interns and residents and 23 had residents only. (See Table 98.) It is significant that 25 of the 69 hospitals with neither interns nor residents on their staffs were 50 to 200 bed hospitals. Thirty-one of the 37 hospitals which reported no attending ward service had neither interns nor residents. Forty-one of the 58 hospitals with open visiting staff policy did not have the services of an intern or resident. (See Table 98.)

Twenty-nine physicians were serving internships in 13 hospitals not approved for intern training. Only one of these 29 physicians had previously completed an approved internship. Fifteen of these interns were graduates of American or Canadian medical schools unaccredited by the New York State Board of Medical Examiners and 8 were graduates of foreign schools. It is significant that (including the 1 who had previously completed an approved internship) only 6 of these 29 interns had graduated from accredited American or Canadian schools of medicine. (See Table 99.)

Twenty-five hospitals reported a total of 43 residents. Thirty-eight of these 43 resident physicians were reported as having had approved internships prior to their present appointment. Six of these residents were graduates of unaccredited American or Canadian schools and 5 had graduated from foreign medical schools. (See Table 100, page 317.)

On the basis of the data received, only 28 of the 72 individual physicians in the group studied would have been unable to utilize the present internship to satisfy licensure requirements under the proposed intern requirement bill.<sup>8</sup> Not more than 13 hospitals

<sup>7</sup> Journal of the American Medical Association (Hospital Number), March 11, 1939, Vol. 112, No. 10.

<sup>8</sup> 1940 Assembly bill Introductory 1420, Mr. Mailler.



among those studied would have found difficulty in filling their intern positions.

The 21 graduates of unaccredited American or Canadian schools would have been unable to secure appointments as interns or residents in hospitals of New York State under the provisions of the proposed bill for excluding graduates of unaccredited medical schools from hospitals.<sup>9</sup>

### *Summary:*

1. Only 36 of the 105 hospitals unapproved for intern training studied have staff interns or residents. Since, 25 of these 36 hospitals had residents only (only 2 had both residents and interns) and 38 of the 43 residents employed had previously completed an approved internship, few of the 105 hospitals studied would be adversely affected by legislation requiring at least one year of internship in an approved hospital as a prerequisite to licensure.

2. The study revealed only 28 physicians without previous approved internships, holding intern appointments at hospitals unapproved for intern training.

3. Graduates of unaccredited medical schools accounted for 21 of the 72 interns and residents reported in hospitals in upstate New York not approved for intern training, despite the fact that such graduates are not eligible for license to practice medicine in this State.

### **Study 3: Intern Experience of Medical Licensees**

Physicians in New York State are not required to present evidence of completion of an internship in order to receive licenses to practice medicine. However, most medical graduates recognize the value of intern training and spend at least one year in hospitals before entering the practice of medicine.

Since an internship is not a prerequisite for a medical license, the New York State Department of Education does not record the intern experiences of the physicians it has licensed. The American Medical Association strives to maintain a complete file on the training and experience of all physicians in the United States. Therefore, the Commission, when it wished to know how many physicians might be affected by legislation requiring intern training for medical licensure in New York State, asked the American Medical Association to supply this information.

The Council on Medical Education and Hospitals of the American Medical Association cooperated by searching their files, for the intern experience of physicians licensed to practice medicine in New York State during the years 1937 and 1938, and tabulated the information obtained.

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<sup>9</sup> 1940 Assembly bill Introductory 2158, Miss Todd.



Information was requested concerning medical schooling and intern experience of recently licensed physicians in New York State as follows:

1. The number of physicians educated in approved American or Canadian schools, foreign schools and unapproved American or Canadian schools.

2. The number of physicians who had completed at least one year of internship in hospitals approved for intern training in New York State, approved hospitals in other states, unapproved hospitals and the number with internships now in progress.

The tabulation of these data for the licensees of the New York State Board of Medical Examiners for the years 1937 and 1938 was forwarded in time for inclusion in this report. This material in the form submitted by the American Medical Association is reproduced as Tables 101a, 101b and 101c, on pages 318-320.

Analysis shows that, of the 3,261 physicians licensed in New York State during the years 1937 and 1938, 202 had taken internships at hospitals unapproved for intern training and 771 had not completed internships or had no record of intern service. (See Table 101a.) Of the 771 physicians with incomplete internship records, 581 (75.3 percent) were graduates of foreign medical schools. Only 5.5 percent in 1937 (see Table 101b) and 6 percent in 1938 (see Table 101c) of the American and Canadian graduates licensed in New York State did not complete a year of intern training. Of the 2,161 completed approved internships 1,404 (65 percent) were completed in hospitals in New York State.

Although graduates of schools not accredited by the New York State Board of Medical Examiners are not eligible for medical licensure in New York State, 23 such graduates achieved New York State licensure during the years 1937 and 1938 by endorsement of licenses issued by other states.

### *Summary:*

1. In spite of the lack of a formal requirement most of the American and Canadian medical graduates completed one year of approved internship, therefore, the proposed legislation requiring a year of approved intern training would impose little hardship on this group. However, more than one-third (1,100) of the 3,261 physicians licensed to practice medicine in New York State during the years 1937 and 1938, either did not serve their internships in a hospital approved for the purpose, had not completed an internship or had no record of intern service—according to the records of the American Medical Association.

2. There is evidence that individuals not eligible for licensure by examination do secure licenses to practice medicine in New York State by endorsement of credentials from other states.

TABLE 95

New York State  
Graduate Medical Education

## Study 1. Opportunities for Intern Training

HOSPITALS APPROVED BY THE AMERICAN MEDICAL ASSOCIATION  
FOR INTERN TRAINING,<sup>1</sup> TOGETHER WITH HOSPITAL BEDS  
AND INTERNSHIPS AVAILABLE CLASSIFIED BY  
TYPE OF CONTROL OF HOSPITAL

	HOSPITALS			HOSPITAL BEDS			INTERNSHIPS AVAILABLE		
	Total New York State	Upstate New York	New York City	Total New York State	Upstate New York	New York City	Total New York State	Upstate New York	New York City
Total—Number.....	102	39	63	41,870	11,322	30,548	1,684	337	1,347
Percent.....	100.0	38.2	61.8	100.0	27.0	73.0	100.0	20.0	80.0
Voluntary—Number.....	80 <sup>a</sup>	34 <sup>a</sup>	46	25,331	8,530	16,801	1,009	271	738
Percent.....	100.0	42.5	57.5	100.0	33.7	66.3	100.0	26.9	73.1
Proprietary—Number.....	2	.....	2	506	.....	506	17	.....	17
Percent.....	100.0	.....	100.0	100.0	.....	100.0	100.0	.....	100.0
Public									
Total—Number.....	20	5	15	16,033	2,792	13,241	658	66	592
Percent.....	100.0	25.0	75.0	100.0	17.4	82.6	100.0	10.0	90.0
City—Number.....	16	3	13	13,713	1,709	12,004	599	30	569
Percent.....	100.0	18.7	81.3	100.0	12.5	87.5	100.0	5.0	95.0
County—Number.....	2	2	.....	1,083	1,083	.....	36	36	.....
Percent.....	100.0	100.0	.....	100.0	100.0	.....	100.0	100.0	.....
Federal—Number.....	2	.....	2	1,237	.....	1,237	23	.....	23
Percent.....	100.0	.....	100.0	100.0	.....	100.0	100.0	.....	100.0

<sup>1</sup> Journal of the American Medical Association (Education Number) Vol. 113, No. 9, Aug. 26, 1939, pages 836-837<sup>a</sup> Includes one hospital (657 beds, 36 internships) which includes a city hospital under its supervision.

TABLE 96

## Graduate Medical Education

## New York State (Exclusive of New York City)

## Study 1. Opportunities for Intern Training

NUMBER AND PERCENT OF GENERAL HOSPITALS (TOGETHER WITH  
HOSPITAL BEDS) APPROVED FOR TRAINING OF INTERNS  
CLASSIFIED BY TYPE OF CONTROL

TYPE OF CONTROL	Number of approved intern- ships available	Total general hospitals <sup>1</sup>	Hospitals approved for intern training <sup>2</sup>	Percent hospitals approved	Total general hospital beds	Beds in hospitals approved for intern training	Percent beds in approved hospitals
<i>Hospitals</i>							
Total general hospitals.....	337	233	39	16.7	26,969	11,322	42.0
Voluntary.....	271	138	34	24.6	16,805	8,530	50.8
Proprietary.....	.....	43	.....	.....	1,699	.....	.....
Public—Total.....	66	52	5	9.6	8,465	2,792	33.0
City.....	30	17	3	17.6	2,899	1,709	59.0
County.....	36	15	2	13.3	3,714	1,083	29.2
State.....	.....	9	.....	.....	525	.....	.....
Federal.....	.....	11	.....	.....	1,327	.....	.....

<sup>1</sup> Preliminary Report of the Commission, Legislative Document (1939), No. 97, Table 6, pages 33-35.<sup>2</sup> Journal of the American Medical Association (Education Number) Vol. 113, No. 9, August 26, 1939, pages 836-837.

TABLE 97  
New York State (Exclusive of New York City)  
Graduate Medical Section

Study 2. Intern and Resident Staffs in Hospitals Not Approved for Intern Training  
GENERAL HOSPITALS NOT APPROVED BY AMERICAN MEDICAL ASSOCIATION FOR INTERN TRAINING, CLASSIFIED  
BY TYPE OF CONTROL AND SIZE OF HOSPITAL

HOSPITALS										BEDS IN HOSPITALS <sup>1</sup>						HOSPITALS HAVING							
TOTAL		VOLUN- TARY		PRO- PRIETARY		PUBLIC		TOTAL		VOLUN- TARY		PRO- PRIETARY		PUBLIC		LESS THAN 50 BEDS		50-99 BEDS		100-199 BEDS		200 BEDS AND OVER	
Num- ber (1)	Per- cent (2)	Num- ber (3)	Per- cent (4)	Num- ber (5)	Per- cent (6)	Num- ber (7)	Per- cent (8)	Num- ber (9)	Per- cent (10)	Num- ber (11)	Per- cent (12)	Num- ber (13)	Per- cent (14)	Num- ber (15)	Per- cent (16)	Num- ber (17)	Per- cent (18)	Num- ber (19)	Per- cent (20)	Num- ber (21)	Per- cent (22)	Num- ber (23)	Per- cent (24)
Total hospitals not approved for intern training by American Medical Association . . . . .																							
163	100.0	104	63.8	22	13.5	37	22.7	11,647	100.0	7,739	66.4	675	5.8	3,233	27.8	78	47.9	46	28.2	33	20.2	6	3.7
Hospitals inappropriate to study <sup>2</sup> . . . . .																							
21	100.0	1	4.8	1	4.8	19	90.4	1,790	100.0	80	4.5	100	5.6	1,610	89.9	11	52.4	5	23.8	3	14.3	2	9.5
General hospitals appropriate to study . . . . .																							
142	100.0	103	72.5	21	14.8	18	12.7	9,857	100.0	7,659	77.7	575	5.8	1,623	16.5	67	47.2	41	28.9	30	21.1	4	2.8
Hospitals not replying to questionnaire by February 10, 1940 . . . . .																							
37	100.0	26	70.3	10	27.0	1	2.7	2,672	100.0	1,996	72.5	236	8.8	500	18.7	22	59.5	7	18.9	7	18.9	1	2.7
Hospitals considered in study																							
105	100.0	77	73.3	11	10.5	17	16.2	7,135	100.0	5,723	79.7	339	4.7	1,123	15.6	45	42.9	34	32.4	23	21.9	3	2.8

<sup>1</sup> Based on total beds as reported in the Journal of the American Medical Association of March 11, 1939.

<sup>2</sup> Consists of 8 United States Army State Hospitals, 1 United States Marine Hospital, 2 Veteran's hospitals, 7 hospitals associated with institutions, 1 hospital discontinued during the year, 1 institution not a hospital, and 1 hospital recently approved for intern training.

TABLE 98  
New York State (Exclusive of New York City)  
GRADUATE MEDICAL EDUCATION  
STUDY 2. INTERN AND RESIDENT STAFFS IN HOSPITALS NOT APPROVED FOR INTERN TRAINING  
105 GENERAL HOSPITALS NOT APPROVED BY AMERICAN MEDICAL ASSOCIATION FOR INTERN TRAINING  
CLASSIFIED BY TYPE OF CONTROL, SIZE OF HOSPITAL AND STAFF ORGANIZATION

ITEM	Number of hospitals	BED CAPACITY <sup>1</sup>					VISITING STAFF POLICY			TYPE OF ATTENDING WARD SERVICE			
		50 beds	50-99 beds	100-199 beds	200-299 beds	Total bed capacity	Open	Closed	Not stated	Perma- nent	Rotating	None	Not stated
All hospitals.....	105	45	34	23	3	7,185	58	38	9	19	40	37	9
Hospitals without interns or residents.	69	44	14	11	.....	3,433	41	19	9	8	23	31	7
Voluntary.....	44	25	10	9	.....	2,400	26	14	4	3	18	20	3
Proprietary.....	11	10	.....	1	.....	339	6	2	3	4	.....	4	3
Public.....	14	9	.....	1	.....	694	9	3	2	1	5	7	1
Hospitals with interns but without residents.	11	.....	6	5	.....	1,119	5	6	.....	1	7	2	1
Voluntary.....	10	.....	6	4	.....	1,002	5	5	.....	1	6	2	1 <sup>a</sup>
Proprietary.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....
Public.....	1	.....	.....	1	.....	117	.....	1	.....	.....	1	.....	.....
Hospitals with both interns and residents.	2	.....	1	.....	1	285	1	1	.....	2	.....	.....	.....
Voluntary.....	1	.....	1	.....	.....	85	1	.....	.....	1	.....	.....	.....
Proprietary.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....
Public.....	1	.....	.....	.....	1	200	.....	1	.....	.....	.....	.....	.....
Hospitals without interns but with residents.	23	1	13	7	2	2,348	11	12	.....	8	10	4	1
Voluntary.....	22	1	13	6	2	2,236	10	12	.....	7	10	4	1
Proprietary.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....
Public.....	1	.....	.....	1	.....	112	1	.....	.....	1	.....	.....	.....

<sup>1</sup> Journal of American Medical Association, Mar. 11, 1939, Vol. 112, No. 10.

<sup>a</sup> Hospital reports ward service, type not stated.



TABLE 99  
New York State (Exclusive of New York City)  
GRADUATE MEDICAL EDUCATION

STUDY 2. INTERN AND RESIDENT STAFF IN HOSPITALS NOT APPROVED FOR INTERN TRAINING

13 GENERAL HOSPITALS WHICH HAVE INTERNS AND ARE NOT APPROVED BY AMERICAN MEDICAL ASSOCIATION FOR INTERN TRAINING CLASSIFIED BY TYPE OF CONTROL, NUMBER OF INTERNS, TYPE OF INTERNSERVICE, MONTHLY SALARY RANGE, AND INTERNS IN THESE HOSPITALS CLASSIFIED BY QUALIFICATIONS

ITEM	Number of hospitals	Hospitals having 1 2 3 4 interns	TYPE INTERN SERVICE (HOSPITALS)				Monthly intern salary range	GRADUATES OF				Interns with record of pre- vious approved intern- ship
			Rotating	Mixed	Straight	Not Reported		All schools	Accred- ited Ameri- can and Can- adian schools	Foreign schools	Unac- credited Ameri- can and Can- adian schools	
All hospitals.....	13	2 8 1 2	7 <sup>a</sup>	5 <sup>a</sup>	2 <sup>b</sup>	1	\$0-60 <sup>c</sup>	29	6	8	15	27
Hospitals with interns but without residents.....	11	2 6 1 2	6	4	1	1	\$0-60 <sup>c</sup>	25	6	7	12	24
Voluntary.....	10	2 6 .. 2	5 <sup>a</sup>	4 <sup>a</sup>	1	1	\$0-60 <sup>c</sup>	22	6	7	9	21
Proprietary.....	1	.. .. 1	1	.. ..	.. ..	.. ..	\$25	3	.. ..	.. ..	3	3
Public.....	.. ..	.. ..	.. ..	.. ..	.. ..	.. ..	.. ..	.. ..	.. ..	.. ..	.. ..	.. ..
Hospitals with both interns and residents.....	2	.. 2 .. ..	1	1 <sup>b</sup>	1 <sup>b</sup>	.. ..	\$35-50	4	.. ..	1	3	3
Voluntary.....	1	.. 1 .. ..	1	.. ..	.. ..	.. ..	\$35	2	.. ..	.. ..	2	2
Proprietary.....	.. ..	.. ..	.. ..	.. ..	.. ..	.. ..	.. ..	.. ..	.. ..	.. ..	.. ..	.. ..
Public.....	1	.. 1 .. ..	.. ..	1 <sup>c</sup>	1 <sup>c</sup>	.. ..	\$50	2	.. ..	1	1	1

<sup>a</sup> Hospital reports both rotating and mixed service.

<sup>b</sup> Hospital reports both mixed and straight service.

<sup>c</sup> One hospital gives in addition, a \$300 bonus on completion of satisfactory internship. This was not considered as part of salary in tabulation.

TABLE 100  
New York State (Exclusive of New York City)  
GRADUATE MEDICAL EDUCATION  
STUDY 2. INTERN AND RESIDENT STAFFS IN HOSPITALS NOT APPROVED FOR INTERN TRAINING  
25 GENERAL HOSPITALS WHICH HAVE RESIDENTS AND ARE NOT APPROVED FOR INTERN TRAINING CLASSIFIED BY  
NUMBER OF RESIDENTS AND RESIDENTS IN THESE HOSPITALS CLASSIFIED BY QUALIFICATION

ITEM	Number of hospitals	Hospitals having				GRADUATES OF				Residents graduated within 5 years	Residents with record of previous approved internship
		1	2	3		All schools	Accredited American and Canadian	Foreign schools	Unaccredited American and Canadian schools		
All hospitals.....	25	11	10	4		43	32	5	6 <sup>a</sup>	37 <sup>b</sup>	38 <sup>b</sup>
Hospitals with both interns and residents.....	2	1	1			3	2		1	1	2
Voluntary.....	1	1				1			1		
Proprietary.....											
Public.....	1		1			2	2			1	2
Hospitals without interns but with residents.....	23	10	9	4		40	30	5	5 <sup>a</sup>	36 <sup>b</sup>	36 <sup>b</sup>
Voluntary.....	22	10	9	3		37	27	5	5 <sup>a</sup>	33 <sup>b</sup>	33 <sup>b</sup>
Proprietary.....											
Public.....	1			1		3	3			3	3

<sup>a</sup> Includes one not stated.

<sup>b</sup> Does not include one not stated.

TABLE 101a  
New York State  
GRADUATE MEDICAL EDUCATION  
STUDY 3. INTERN EXPERIENCE OF MEDICAL LICENSEES  
HOSPITAL SERVICE AND SCHOOL OF GRADUATION OF LICENSEES  
OF THE NEW YORK STATE BOARD OF MEDICAL EXAMINERS<sup>1</sup>  
1937 and 1938

Hospital service	Total
Internship of at least one year in approved hospital in New York.....	1,404
Internship of at least one year in approved hospital outside of New York.....	757
Unapproved internship of at least one year.....	202
Incomplete internship or no record of intern service.....	771
Internship now in progress in New York.....	107
Internship now in progress outside of New York State.....	19
Total Licensees 1937 and 1938.....	3,261

School of graduation	Licensed by examina- tion	Licensed by endorse- ment	Total by examina- tion and endorse- ment
Graduate of approved medical school in the United States and Canada.....	1,318	811	2,129
Graduate of foreign medical school.....	831	276	1,107
Graduate of unapproved medical school.....		23	23
Unclassified medical school (prior to 1907).....		2	2
Total Licensees 1937 and 1938.....	2,149	1,112	3,261

<sup>1</sup> Based on data submitted by courtesy of the Council on Medical Education and Hospitals of the American Medical Association.

TABLE 101b  
New York State

## GRADUATE MEDICAL EDUCATION

## STUDY 3. INTERN EXPERIENCE OF MEDICAL LICENSEES

MEDICAL LICENSEES CLASSIFIED BY HOSPITAL SERVICE AND  
SCHOOL OF GRADUATION BY METHOD OF LICENSURE<sup>1</sup>

1937 List

## NEW YORK STATE BOARD OF MEDICAL EXAMINERS

Hospital service	Licensed by examina- tion	Licensed by endorse- ment	Total by examina- tion and endorse- ment
Internship of at least one year in approved hos- pital in New York.....	588	175	763
Internship of at least one year in approved hos- pital outside of New York.....	172	264	436
Unapproved internship of at least one year.....	90	38	128
Incomplete internship or no record of intern service.....	208	190	398
Internship now in progress in New York.....	11	1	12
Internship now in progress outside of New York..	1	.....	1
Totals.....	1,071	668	1,739

Of 398 incomplete internships, 305 were held by foreign gradu-  
ates and 93 by students from American or Canadian schools. Ac-  
cordingly, only 5.5 percent of the American and Canadian gradu-  
ates licensed in New York State during 1937 did not complete a  
year of intern training.

School of graduation	Licensed by examina- tion	Licensed by endorse- ment	Total by examina- tion and endorse- ment
Graduate of approved medical school in the United States and Canada.....	673	433	1,106
Graduate of foreign medical school.....	398	220	618
Graduate of unapproved medical school.....	.....	14	14
Unclassified medical school (prior to 1907).....	.....	1	1
Totals.....	1,071	668	1,739

<sup>1</sup> Data as submitted by courtesy of the Council on Medical Education and Hospitals of the American Medical Association.



TABLE 101c  
New York State

## GRADUATE MEDICAL EDUCATION

## STUDY 3. INTERN EXPERIENCE OF MEDICAL LICENSEES

MEDICAL LICENSEES CLASSIFIED BY HOSPITAL SERVICE AND SCHOOL OF GRADUATION BY METHOD OF LICENSURE <sup>1</sup>

1938 List

## NEW YORK STATE BOARD OF MEDICAL EXAMINERS

Hospital service	Licensed by examina- tion	Licensed by endorse- ment	Total by examina- tion and endorse- ment
Internship of at least one year in approved hos- pital in New York.....	470	171	641
Internship of at least one year in approved hos- pital outside of New York.....	130	191	321
Unapproved internship of at least one year.....	59	15	74
Incomplete internship or no record of intern service.....	311	62	373
Internship now in progress in New York.....	92	3	95
Internship now in progress outside of New York..	16	2	18
Totals.....	1,078	444	1,522

Of 373 incomplete internships, 276 were held by foreign gradu-  
ates and 97 by students from American or Canadian schools.  
Accordingly, only 6 percent of the American and Canadian gradu-  
ates licensed in New York State during 1938 did not complete a  
year of intern training.

School of graduation	Licensed by examina- tion	Licensed by endorse- ment	Total by examina- tion and endorse- ment
Graduate of approved medical school in the United States and Canada.....	645	378	1,023
Graduate of foreign medical school.....	433	56	489
Graduate of unapproved medical school.....	.....	9	9
Unclassified medical school (prior to 1907).....	.....	1	1
Totals.....	1,078	444	1,522

<sup>1</sup> Data as submitted by courtesy of the Council on Medical Education and Hospitals of the American Medical Association.

## Chapter VI

### HEALTH INSURANCE

This chapter is devoted to a detailed consideration of insurance, voluntary or compulsory, as one of the methods for the distribution of medical care.

The Commission immediately recognized that while compulsory health insurance is one of the methods of distributing medical care, it is primarily a procedure for pooling funds contributed by insured persons and their employers, using such funds to pay for such medical care and to provide cash benefits to the insured during the periods of disability. It was recognized by the Commission that the medical needs of wage earners, including their dependents, with fixed income levels, could be met in many ways which differed, one from the other, both with respect to the scope of medical services provided and the methods by which such services were distributed, supervised and paid for.

Compulsory health insurance, therefore, should be considered in the light of its development in foreign countries, the applicability of such development to New York State, and its relationship to other methods of distributing medical care which might be more appropriate to conditions prevailing in New York State. Hence, the studies made by the Commission of existing and proposed schemes for public provision of medical care, and studies of voluntary hospital services and medical care insurance programs should be carefully weighed, together with the private practice of medicine, in the evaluation of this study of Health Insurance.

#### PART I. INTRODUCTION

Due to tremendous scientific and technical progress during the last half century medicine has become more efficient than ever before. At the same time medical care has become increasingly complex. Medical practice in all its phases—observation, diagnosis and treatment of the sick has been definitely shifting from the sphere of the home to hospitals<sup>1</sup> and other centers. The cost of practicing medicine has steadily risen due to the need for huge capital investment in equipment and increased current expenditures for the provision of good medical care.

Ever mounting medical bills have imposed new burdens on the pocketbook of each patient. Profound changes in economic conditions and the social structure, coinciding with equally profound changes in the science and art of medicine, have affected the purchasing power<sup>2</sup> of the people. This inevitably has influenced the economic status of the physician in the community.<sup>3</sup>

<sup>1</sup> Tables 102-104 on Hospital Facilities and Extent of General Hospital Care, see pp. 3024-325.

<sup>2</sup> Table 105 on Distribution of Incomes in 1935-36, see p. 325.

<sup>3</sup> Table 106 on Income of Physicians, see p. 326.

Modern society is faced with these problems: How shall preventive and curative medicine be made available to all of the people without discrimination? How shall available medical resources, knowledge and skill be organized for distribution? How can medical care be furnished at a price which is fair to both patient and physician?

There are various ways of adapting modern medicine to modern social and economic requirements. This chapter is devoted to a detailed consideration of insurance as one of the methods by which a solution of this problem has been attempted or proposed.

### **Illness—An Insurable Risk**

By applying the principle of insurance, it is claimed that not only can we avoid, or reduce, the financial burden and economic losses due to ill-health, but we can contribute also to the health of the individual and the community.

The experience of commercial insurance companies shows that illness is an insurable risk because costs for the individual due to sickness, injury or maternity are uncertain and variable, unpredictable, unbudgetable and often disastrous. Costs of illness for a large group can be predicted and budgeted.

Prediction and budgeting is possible because the "Law of Averages" and the actuarial principle can be applied to illness as well as to death. An accurate measurement of potential risks, however, can be made only for large groups of people and over periods of time.

"Health Insurance", voluntary or compulsory, may be defined as a method of pooling risks and resources to budget and pay the costs of medical care and/or compensate for loss of earnings due to disability. The organization of many people under a single plan is considered necessary to pool the risks. The technique of small periodic prepayments is a method used to pool the resources.

### **Various Types of "Health Insurance"**

Insurance against the economic and social risks of ill health may be organized for the purpose of furnishing services necessary to maintain or restore good health. Hence the concept of "health insurance" in terms of service plans providing for one or a variety of services in return for regular prepayments in cash.

Insurance against the economic risks of ill health may be organized for the purpose of paying cash to the insured, in a certain proportion to the economic losses due to illness. Then the concept is of "health insurance" in terms of indemnity or cash plans providing for reimbursement of medical expenses or compensation for loss of income or both in return for regular prepayments in cash.

Insurance against the risks of ill health may be organized so as to combine both provision of services in cash or in kind as well as compensation for disability.



Two procedures can be used to apply the insurance principle to medical care: voluntary cooperation of a number of individuals or groups; or a governmental requirement that certain economic or occupational groups join a scheme safeguarded, guaranteed and assisted by law.

### Various Methods of Distributing Services under Health Insurance

There is no innate relationship between the mechanism of distributing medical care and the method of paying for the costs of such care.

Services may be distributed on the basis of the individual practice of medicine and paid for through a prepayment arrangement.

Under programs conducted on the principle of individual practice an indefinite number of physicians may participate in the plan; their number is determined by their willingness to work at terms and conditions mutually agreed upon. Just as the physician is free to join the plan, the patient is free to choose his doctor from among those participating. The physicians usually are compensated either on the basis of a fee schedule established for this purpose, or on a capitation basis, or on a combination basis.

Services may be distributed on the basis of the group practice of medicine and financed by regular prepayments.

Group practice may be defined as the cooperative practice of medicine by physicians for the purpose of pooling experience, equipment and earnings.

Under plans based on the principle of group practice<sup>4</sup> medical care is furnished by an organized group of physicians, dentists, pharmacists, nurses and other related personnel; their type and number are determined by the size of the population group to be served.

Usually services of the professional group are distributed from a center, such as a clinic or hospital. The patient is free to choose from the physicians on the staff of the group. The professional men and their aides usually receive fixed salaries and enjoy a number of privileges such as time off during the week, rotating service during nights and holidays, paid vacations, and an opportunity for post-graduate study.

Dr. Hugh Cabot,<sup>5</sup> in commenting on group practice makes the following statement: "This development has evidently come about as the result of changing conditions of two kinds—medical and economic. The medical reason for the development of the group is the self-evident fact that the individual practitioner is in constant need of advice and assistance from colleagues who have devoted their time to special fields. The conception thus arose that the effectiveness of the general practitioner might be increased by directly associating with himself the commonly necessary special

<sup>4</sup> Group Medical Practice, Committee on Research in Medical Economics, 1940.

<sup>5</sup> Cabot, Hugh. *The Doctor's Bill*. Columbia University Press, N. Y., 1935, p. 69.



consultants. Assuming good judgment in the selection of the group, no argument is necessary to show that it can offer a superior grade of service.

"On the economic side, a wisely arranged association of general and special practitioners will obviously have the result of making possible very large savings in overhead, which, today, particularly in the case of the specialist, has become a very important charge against his gross income. That this does, in fact, occur has been frequently denied, chiefly by the various groups commonly referred to as 'organized medicine.'

"That the formation of a group does in some magical way alter the individual characteristics of its members is not here asserted, but it is asserted that by sound organization the group can diminish overhead charges. Insofar as decrease in expense for overhead operates to increase the net income of the group, it will be possible for the group to offer their services to the community at a lower figure. This amounts, of course, simply to passing on to the consumer the benefits obtained by better organization, a maxim which has dominated business for many years."

The proponents of the individual practice of medicine believe that group practice, especially on an insurance basis, will result in an undesirable limitation to the patient of free choice of his physician, as well as an impairment of the quality of medical care provided through a system of regimentation and lay control.

The platform of the American Medical Association advocates "The continued development of the private practice of medicine, subject to such changes as may be necessary to maintain the quality of medical care and to increase its availability."

Various approaches may be used in efforts to organize collective as contrasted to individual purchase of medical care, either on the basis of the individual or the group practice of medicine. The forces of the "producers," namely the physicians and allied professions, may be organized without changing the old-established method of finance;—a fee for a service; the resources of the "consumers" of medical care may be organized by the development of prepayment plans without changing the traditional system of individual practice. Finally, these and other methods of distributing and compensating services may be combined.

#### Source Material (Tables 102–106)

TABLE 102

#### *Hospital Facilities in the United States—All Types:*

Year	Number of hospitals	Number of beds
1873 .....	149	35,453
1909 .....	4,359	421,065
1914 .....	5,037	532,481
1928 .....	6,852	892,934
1934 .....	6,334	1,048,101
1938 .....	6,166	1,161,380

TABLE 103

*General Hospitals in the United States:*

Year		Number of hospitals	Number of beds
1927	Government .....		
	Non-governmental .....		
	Grand total .....	4,322	345,364
1934	Government .....		
	Non-governmental .....		
	Grand total .....	4,198	393,425
1938	Government .....	780	147,350
	Non-governmental .....	3,506	277,974
	Grand total .....	4,286	425,324

TABLE 104

*Extent of General Hospital Care in the United States:*

Year		Number of patients admitted	Average census of patients	Number of patient days
1927	Government .....			
	Non-governmental .....			
	Grand total .....		228,084	
1934	Government .....			
	Non-governmental .....			
	Grand total .....	6,291,556	237,395	
1938	Government .....	2,170,189		
	Non-governmental .....	6,375,741		
	Grand total .....	8,545,930	202,870	106,897,550

TABLE 105

## 1935-1936 DISTRIBUTION OF INCOME IN THE UNITED STATES

INCOME LEVEL	FAMILIES AND SINGLE INDIVIDUALS			AGGREGATE INCOME		
	Number	Per cent at each level	Cumulative P. C.	Amount (in thousands)	Per cent at each level	Cumulative P. C.
Under \$250 .....	2,123,534	5.38	5.38	\$294,138	0.50	0.50
\$250-\$500 .....	4,587,377	11.63	17.01	1,767,363	2.98	3.48
\$500-\$750 .....	5,771,960	14.63	31.64	3,615,653	6.10	9.58
\$750-\$1,000 .....	5,876,078	14.90	46.54	5,129,506	8.65	18.23
\$1,000-\$1,250 .....	4,990,995	12.65	59.19	5,589,111	9.42	27.65
\$1,250-\$1,500 .....	3,743,428	9.49	68.68	5,109,112	8.62	36.27
\$1,500-\$1,750 .....	2,889,904	7.32	76.00	4,660,793	7.87	44.14
\$1,750-\$2,000 .....	2,296,022	5.82	81.82	4,214,203	7.11	51.25
\$2,000-\$2,250 .....	1,704,535	4.32	86.14	3,602,861	6.08	57.33
\$2,250-\$2,500 .....	1,254,076	3.18	89.32	2,968,932	5.01	62.34
\$2,500-\$3,000 .....	1,475,474	3.74	93.06	4,004,774	6.76	69.10
\$3,000-\$3,500 .....	851,919	2.16	95.22	2,735,487	4.62	73.72
\$3,500-\$4,000 .....	502,159	1.27	96.49	1,863,384	3.14	76.86
\$4,000-\$4,500 .....	286,053	.72	97.21	1,202,826	2.03	78.89
\$4,500-\$5,000 .....	178,138	.45	97.66	841,766	1.42	80.31
\$5,000-\$7,500 .....	380,266	.96	98.62	2,244,406	3.79	84.10
\$7,500-\$10,000 .....	215,642	.55	99.17	1,847,820	3.12	87.22
\$10,000-\$15,000 .....	152,682	.39	99.56	1,746,925	2.95	90.17
\$15,000-\$20,000 .....	67,923	.17	99.73	1,174,574	1.98	92.15
\$20,000-\$25,000 .....	39,825	.10	99.83	889,114	1.50	93.65
\$25,000-\$30,000 .....	25,583	.06	99.89	720,268	1.22	94.87
\$30,000-\$40,000 .....	17,959	.05	99.94	641,272	1.08	95.95
\$40,000-\$50,000 .....	8,340	.02	99.96	390,311	.66	96.61
\$50,000-\$100,000 .....	13,041	.03	99.99	908,485	1.53	98.14
\$100,000-\$250,000 .....	4,144	.01	100.00	539,006	.91	99.05
\$250,000-\$500,000 .....	916	.*		264,498	.45	99.50
\$500,000-\$1,000,000 .....	240	.*		134,803	.23	99.73
\$1,000,000 and over .....	87	.*		157,237	.27	100.00
All levels .....	39,458,300	100.00		\$59,258,628	100.00	

\* Less than 0.005 percent.

In New York State, of the approximately 4 million employees covered by the old age insurance provisions of the Social Security Act, in 1937, 56.2 percent were in wage classes of under \$1,000 per year, and 86.4 percent in wage classes under \$2,000 (Monthly Bulletin, April 1939, p. 17).

*Income of Physicians.—*

TABLE 106

PROFESSIONAL INCOME OF PHYSICIANS IN PRIVATE PRACTICE,  
1929. BY SIZE OF COMMUNITY <sup>6</sup>

Size of community	Median Income	
	Gross	Net
All communities .....	7,026	4,100
Under 5,000 population.....	4,372	2,500
5,000 to 9,999 .....	7,424	4,500
10,000 to 24,999 .....	8,574	5,150
25,000 to 49,000 .....	9,308	5,600
50,000 to 99,999 .....	8,950	5,500
100,000 to 499,999 .....	8,768	5,400
500,000 to 999,999 .....	8,303	5,200
1,000,000 and over.....	8,254	4,700

In 1929, complete specialists had an average net income of \$10,000; partial specialists of \$6,100; general practitioners of \$3,900. Fifteen percent of the general practitioners earned less than \$1,500 and 30 percent less than \$2,500 (Committee on the Costs of Medical Care).

In a paper recently delivered before the meeting of New York County Medical Society on Economic Conditions of Physicians in New York City, Dr. Ernest P. Boas pointed out that the most recent studies show a tremendous drop in income from the year 1929 to 1933, a "drop that reaches between 50 percent and 60 percent. I have obtained from the Bureau of Medical Economics of the American Medical Association the data that they have available. They represent surveys made in many parts of the country, in small and large communities. From a consideration of all the figures, I believe that it is fair to estimate that the average net income of the general practitioner in the year 1936 was about \$3,500—the median was less."

<sup>6</sup> Leven, Maurice, The Income of Physicians, Publication No. 24 of the Committee on the Costs of Medical Care.



## PART II. VOLUNTARY HEALTH INSURANCE

WITH SPECIAL REFERENCE TO PLANS OPERATING OR PROPOSED  
IN NEW YORK STATE

## Sponsors of Voluntary Health Insurance

There is a great variety of organizations which may assume—in fact, have already assumed—responsibility for developing voluntary plans based on the application of the insurance principle. The sponsors may be classified by their approach: one group handles different types of plans on a commercial or profit basis; the other group sponsors non-profit arrangements.

Outstanding examples in the first group are commercial insurance companies, writing either individual insurance or group insurance. Well-known sponsors in the second group (listed in the order of historical development) are mutual benefit associations, fraternal orders, industry and business, unions, colleges and universities, consumer cooperatives, voluntary agencies, medical societies and other groups of physicians.

It is hard to describe common elements in all of these developments because of the great variety of pioneering organizations and the widely varying type of approach. However, there has been a definite trend towards developing the contributory principle and emphasizing the provision of services.

## Commercial Insurance against the Risks of Ill-health

Recommendation Number 4 of the New York State Temporary Legislative Commission to Formulate a Long Range State Health Program specifically called for further investigation of commercial insurance plans:

“Studies of voluntary hospital service and medical care insurance programs and the extent to which, in the light of the amended Constitution of the State of New York, they protect her citizens against the hazards of sickness. Also, an appraisal should be made of the relative significance of commercial health and hospital expense insurance, in relation to non-profit voluntary plans in operation.”<sup>7</sup>

*Characteristics of Commercial Insurance.*—Commercial insurance is a method whereby an individual, or group of individuals, agrees to pay a fixed periodic sum in return for which is received a specified amount of money upon the occurrence of death, dismemberment, or disability resulting from accident or sickness. The contract calls for the payment of money benefits. Medical and hospital services as such are not supplied. The amount of

<sup>7</sup> Preliminary Report of the New York State Temporary Legislative Commission to Formulate a Long Range State Health Program, Legislative Document (1939) No. 97, p. 6.



indemnity may be payable in a lump sum for loss of life or dismemberment, as a weekly indemnity for disability and loss of income, or for the payment of medical expenses.

*History:* Originally commercial insurance was handled on the basis of individual insurance. Commercial health insurance was first written in the United States in 1847. In 1863 accident insurance was offered. Disability insurance was introduced about 1898. In 1896 life insurance companies added total and permanent disability clauses. Until 1915 accident and health insurance was written on a one-year term and was cancellable at any time by the company. In 1915 noncancellable accident and health policies were originated. Since 1911 group life and disability insurance was emphasized; accident and sickness insurance was offered to people enrolling in groups and extended to include non-occupational accidents and all sickness.

*Types of Insurance:* Accident and health insurance is written by private stock or mutual insurance companies (mostly life or casualty insurance companies).

*Types of Policies:* It has been estimated that 40 percent of all new life contracts contain disability clauses. In 1930, 250 life insurance companies offered this type of protection and 52 million dollars was paid out in cash benefits to the country as a whole.

Comparison of the net cost of disability income clauses found in life insurance policies has revealed<sup>8</sup> that the cost of providing a total disability income of \$100 a month varied from \$88.73 per year to \$169.92. The figures for a company of medium cost for life disability income, if the disability occurs before the age of 55, were made up of \$71.20 extra premium for the addition of the disability clause in the ordinary life insurance policy, plus \$77.78 correction for the cost of life insurance, and less \$11.50 as a correction for the waiver of premium—a total of \$137.48 representing the annual cost.

*Accident and Health Insurance:* A review of nine standard guide policy forms prepared by the Bureau of Personal Accident and Health Underwriters reveals that in general such policies are more or less custom-built and vary tremendously both from the standpoint of benefits and cost of premiums.

Factors such as cancellable and renewable clauses in policies, amount of disability income, duration of income, definition of total and permanent disability, waiting periods, waiver of premiums, age limitations and multiple other limitations, and exclusions greatly effect both the cost and protection derived from this type of health insurance.

*Group Insurance:* Group insurance is a plan by which a number of individuals forming a group are insured under a simple blanket

<sup>8</sup> Harwood, E. C., and Frances, Bion H. Life Insurance from the Buyer's Point of View. American Institute for Economic Research, Cambridge, Mass., 1939, p. 222.

policy. Coverage usually applies to death and disability. This type of insurance is often purchased by employers for all employees of the respective corporation.

On January 1,<sup>9</sup> 1931, the figures for the companies writing group disability insurance showed a coverage of 1,905,000 lives for temporary disability with weekly benefits amounting to \$18,359,000.

In 1938, eight large companies wrote more than 90 percent of all the group insurance policies in force. There were 1,764 group accidental death and dismemberment policies for 505,278 employees and 4,475 group accident and health policies for 1,228,910 employees.

*Selection of Policyholders:* In general, individuals under the age of 18 or over the age of 55 or 60 are not eligible for accident and health insurance. Certain policies are restricted to favorable risk groups, such as business and professional people. Women are discriminated against in a number of policies available and occasionally groups subject to more than the ordinary hazard are not solicited.

*Study to Determine the Extent of Coverage of the Population of New York State by Health and Accident Insurance.*—This Commission has been advised by the Insurance Department of the State of New York that there are at least 161 companies authorized to write health and accident insurance business in the State of New York. Questionnaires were sent to 101 of these companies, of which 58 were stock casualty companies and 11 were stock life insurance companies. The questionnaires sent to these companies represented an attempt to determine for New York State for the years 1936 and 1939 inclusive the following:

1. The number of policyholders in force.
2. The net premiums written.
3. The losses paid.
4. The average premium paid per policyholder.
5. The average amount of losses paid for policyholder.

This information was to be subdivided among the following classifications:

- A—Accident business only.
- B—Health business only.
- C—Accident and health business combined.
- D—Hospitalization business.
- E—Non-cancellable accident and health business.
- F—Group accident and health business.
- G—The total of all classes of accident and health business.

A similar classification of information was requested from the same companies using the same type of schedules for their busi-

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<sup>9</sup> Williams, Pierce—*The Purchase of Medical Care Through Fixed Periodic Payment*. National Bureau of Economic Research, Inc., 1932. J. J. Little and Ives Company, New York, p. 272.

ness during the year ending December 31, 1938, designed to show a breakdown of the various income groups purchasing such policies. The income groups for which such information was requested, ranged from those beginning with an income of \$1,000 or less to those of \$3,000 or over.

*Results:* The results of this survey were very discouraging. Forty-eight of the companies canvassed replied that it was impossible to furnish the information. A few companies, not sufficient for a representative sample, offered figures on the number of policyholders and premiums, and amount of such insurance written together with the losses paid out. No companies were able to give usable information on the income groups of their policyholders. However, due to the courtesy of "The Spectator," an insurance publication, the following table was furnished to the Commission, which indicates the accident business, health business and non-cancellable accident and health business carried on in the State of New York.

It can readily be seen that only a small proportion of the population is covered by accident and health insurance.

TABLE 107

ACCIDENT AND HEALTH BUSINESS IN NEW YORK STATE<sup>10</sup>

<i>Accident Business</i>			
	Net premiums written	Losses paid	Estimated number of individual policyholders
1938 .....	10,438,258	3,588,158	629,903
1937 .....	11,474,779	3,159,458	687,488
1936 .....	8,439,542	3,120,987	518,863
1935 .....	7,847,246	3,130,440	485,958
1934 .....	7,349,090	3,449,954	459,283
<i>Health Business</i>			
1938 .....	5,302,953	3,174,249	381,436
1937 .....	4,524,491	3,046,750	332,781
1936 .....	4,769,050	2,636,212	348,066
1935 .....	4,272,078	2,412,866	317,005
1934 .....	3,885,370	2,222,251	292,836
<i>Non-cancellable Accident and Health Business</i>			
1938 .....	1,832,548	1,505,542	52,359
1937 .....	1,646,339	1,540,851	47,038
1936 .....	1,561,637	1,538,139	44,618
1935 .....	1,528,366	1,476,839	43,668
1934 .....	1,528,209	1,414,276	43,663

<i>Hospitalization Business</i>			
1938 .....	8,906,094	6,176,259	809,645

<sup>10</sup> Letter Nov. 10, 1939, from L. S. Fischer, The Spectator, Philadelphia, Penna.



"The source from which we obtained the information unfortunately does not detail the number of individuals who buy such insurance. Therefore, we have indicated the estimated number of individuals based on an average premium charged for each line written. The reason we were compelled to take an average premium is because the rate varies, depending upon the type of policy selected, occupation, etc., and because of this, it was impossible to get an accurate number of individuals. However, we feel that our estimate based on a test premium is reasonably representative of the total number of individuals holding such insurance in the State of New York."

### **Non-profit Free-choice Plans Offering Insurance against Costs of Hospitalization**

Attempts to remove or at least reduce for the patient the economic burden of hospitalization have passed through two phases of development.

For many years commercial insurance companies, industrial and business corporations, mutual benefit associations, educational institutions and others have employed the method of insurance to cover costs of hospital care. More recently consumer cooperatives and groups of physicians have offered hospitalization coverage as part of another type of medical care program.

The technique of insurance against the costs of hospitalization has been used on a broad basis by the establishment of non-profit free-choice plans for hospital care. The basic principle of these plans is group budgeting of hospital care by group prepayment. A common fund is built up from prepayments, made by subscribers to the plan, and hospital expenses are paid in part or in full out of the revenues. Group membership is emphasized—often required—because it is requisite for sound operation of the plan.

Group enrollment, usually through places of employment, makes possible waiver of preliminary medical examination. Subscribers have free choice among "member hospitals." The services offered usually cover 3-4 weeks of hospitalization each year (semi-private accommodation), general nursing, use of operating and delivery room, routine laboratory services and certain medications.

There are wide variations in scope and amount of service under the various plans in operation. Usually excluded are services for patients suffering from tuberculosis, venereal diseases, acute communicable diseases, mental and nervous disorders, chronic illness existing prior to membership, and for cases covered by workmen's compensation.<sup>11</sup>

To be eligible for this service subscribers must pay in advance fees ranging from 50 to 85 cents per month per individual or from \$1 to \$2 per month per family.

This movement dates back to 1929 when Baylor University, in Dallas, Texas, made an agreement with 1,500 school teachers to

<sup>11</sup> Rorem, C. Rufus, *Non-Profit Hospital Service Plans*, 1940.



provide three weeks hospitalization in return for a fixed prepayment. The idea spread rapidly, particularly during the last 5 years. By January 1, 1940, there were 60 non-profit free-choice hospital plans in operation for about 4½ million people as contrasted to one plan with 2,000 members in 1933. Plans of this type were given legal status in New York State by legislative action in 1935. So far, 24 states, representing a population of about 88 million, have passed enabling acts for non-profit hospital service plans. Nine states have ruled, through their attorneys general or departments of insurance, that non-profit hospital service plans are not "insurance" and have permitted them to operate under the general corporation laws, exempt from the regulations covering stock and mutual insurance companies. The "Associated Hospital Service of New York," established in 1935, is notable for its large enrollment, covering 1,358,000 people in the 17 counties in the metropolitan area by January 1, 1940. Other plans covering New York State have headquarters in Rochester (coverage 131,427 persons); Syracuse (coverage 92,565 persons); Buffalo (coverage 96,893 persons). In addition, plans are in operation from Albany (coverage 44,237 persons) Geneva, Jamestown, Utica (coverage 51,367 persons) and Watertown.

The plans operating in New York State are under continuous supervision by the State Department of Insurance. However, preliminary to incorporation, a plan is reviewed by the State Department of Social Welfare to determine that payments to hospitals cover reasonable costs of good service, and by the State Department of Insurance to determine that premiums are sufficient to meet these payments to hospitals. The restrictions placed on the establishment of new groups has provided a partial monopoly for already existing plans and prevented unnecessary local competition.

Trends and developments in this field are revealed in the experience of the "Associated Hospital Service of New York"<sup>12</sup> which "has grown to the position where it is paying eight million dollars a year for the hospital care of subscribers. Hospital bills totalling more than sixteen million dollars have been paid by this voluntary non-profit plan since it was established five years ago.

"With an enrollment of more than 1,350,000 persons, or one out of six in the New York area, Associated Hospital Service is the largest of sixty non-profit hospital plans throughout the United States. The number of our subscribers increased more than a quarter of a million during 1939.

"Our financial condition as of December 31, 1939, determined by the New York State Department of Insurance, shows admitted assets of \$4,198,220.26. A surplus of \$1,651,249.71 is available for the added protection of subscribers.

"We have again received the annual certificate of approval awarded by the American Hospital Association for evidence of progress, sound administrative policies and procedures and a financial position which protects your interests.

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<sup>12</sup> Report of Progress (1940).

"As our experience in this new field increased, we have made adjustments in our service for your protection. We have gone forward with continuous cooperation of our subscribers, our more than 270 member hospitals and the medical profession."

The developing of non-profit free-choice hospital plans, sponsored by a group of participating member hospitals and community representatives, is highly significant and important. It stimulates general interest in the method of prepayment for medical care; emphasizes the provision of services rather than cash indemnity; shows how the financial burden of high cost illness, usually requiring hospitalization, can be alleviated for the patient, and tends to give the physician more freedom in suggesting types of treatment, hitherto not easily accessible to many patients.

Hospitals also benefit from these new plans—through assurance of a regular and substantial income. It has been a noble tradition of voluntary hospitals to use surplus income from high cost private room accommodations together with revenues from philanthropic sources to provide free care. A steady decrease in the use of private rooms and in hospital income from philanthropy, together with increasing demand for free care, ward service, and semi-private accommodations brought many voluntary hospitals into financial distress. During a sample month in 1930, among 150 voluntary hospitals in New York City, one-third of the private and semi-private beds were empty and in 1934 one-half.<sup>13</sup>

During 1934 some 332,452 persons who were unable to pay anything for their care were admitted to voluntary and governmental hospitals in New York City. This was nearly 60 percent of all hospital patients.

During the recent economic depression years the number of days provided for public charge patients in voluntary hospitals went up considerably while the number of pay or part pay patients went down. During this period the number of free care hospital days decreased from approximately 1 million to 750 thousand, a reduction of 25 percent.

These facts indicate that hospitals as well as patients may be benefited by voluntary insurance against the economic risks due to illness.

Yet, for the patient and the community, existing group hospital plans meet only a part of the need. Payments for the services of physicians as well as hospitalization for socially important diseases or conditions are excluded from the plans. The duration of hospital service is limited, old people usually can not qualify as subscribers, and the service as it stands is accessible only to the economic groups of the population eligible to subscribe and able to pay the premiums.

The attitude of the hospital and the physician to these developments is indicated in statements endorsed by their national organizations.

<sup>13</sup> Davis, Michael M., *Tough Facts About Hospitals*, The Survey, July 1937, pp. 219-220.

As early as 1933 the American Hospital Association endorsed the insurance principle for the purchase of hospital care, shortly after the Committee on the Costs of Medical Care had published the result of its five-year study. In 1938 a "Council on Hospital Service Plans" was established and the Commission on Hospital Service published standards to coordinate and promote the movement in this country. In the same year, and again in 1939, the American Hospital Association at its annual conventions pointed out "that the prevalent restriction to private and semi-private hospital service, and the omission of any provision for physicians' fees in hospitalized cases, had placed the benefits of prepayment plans beyond the reach of many employed workers of limited income. . . ." It emphasized "the importance and the desirability of applying the principle of voluntary insurance to both hospital and medical service for hospitalized cases among low income groups."

The American Medical association, when considering the National Health Program in 1938, formally approved "the principle of hospital service insurance," emphasized it was "susceptible of great expansion along sound lines" but stated "these plans should confine themselves to provision of hospital facilities and should not include any type of medical care."

According to a recent study<sup>14</sup> the potential enrollment in voluntary hospital service plans will not be such as to solve the problem on a large scale because ". . . those who have sought membership have been largely members of families with incomes of \$2,000 or more, the majority of members belonging to the income class from \$2,000 to \$3,000. Even if the total population in this income class were enrolled in hospital care insurance plans, only 11.5 percent of the entire population would be covered. Since four families out of five in the United States have annual incomes under \$2,000 a year, it seems likely that some other or less expensive plan will have to be evolved to meet the costs not only of hospitalization but of other medical care services for these low income families."

### **Prepayment Plans for Medical Care, Covering Physicians' Care or a Variety of Services**

*General Characteristics.*—The rapid development of prepayment plans for hospital care clearly indicates the public's strong interest in the method of insurance. Both the achievements and the shortcomings of non-profit free-choice hospital plans appear to have accelerated efforts to develop similar mechanisms for services other than hospital care.

In various parts of the country prepayment plans covering a variety of fundamental medical services have been in operation for a number of years and new programs are announced each month.

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<sup>14</sup> Klem, Margaret C., *Family Outlay for Hospital Care*, Modern Hospital, 1939, Vol. 52, p. 45.



These plans may be roughly classified in two groups: First there are service plans in operation offering physicians' care at home, office and hospital, dentists' care, hospitalization, ambulance service, laboratory services, x-ray services, physical therapy services, drugs and bedside nursing at home, or a varying combination of a number of these services. Second, there are plans based on the principle of reimbursement of cash indemnity for physicians' care exclusive of other services or in combination with group hospital plans. The first mentioned type of plan usually is operated on the basis of group practice and sponsored either by groups of consumers or groups of physicians. Some examples are "The Farmers Union Cooperative Hospital Association," Elk City, Oklahoma; "Stanocola Employees' Medical and Hospital Association," Baton Rouge, La.; "Group Health Association," Washington, D. C.; "Greenbelt Health Association," Greenbelt, Md.; "Centro Asturiano," Tampa, Fla.; "Ross-Loos Medical Group," Los Angeles, Cal.; "Milwaukee Medical Center," Milwaukee, Wis.; "Trinity Hospital," Little Rock, Ark.

The second type of plan, providing "cash indemnity" for medical expenses is conducted on the basis of individual practice and is usually sponsored by a local organization of physicians. Some examples are: "The King County Medical Service Bureau," Seattle, Wash.; "Medical Service Bureau," Atlanta, Ga.; "Columbia Medical Society Mutual Health Association," Washington, D. C.; "Western New York Medical Plan," Buffalo, N. Y.; "Medical and Surgical Care," Utica, N. Y.; "Associated Health Foundation," New York City."

"The Spaulding Employees' Mutual Benefit Association," Binghamton, N. Y., is an instance of a plan under which reimbursement in cash is given for a variety of medical services, including hospitalization.

"Cash indemnity insurance plans to cover, in whole or in part, the costs of emergency or prolonged illness" have been advocated by the American Medical Association which officially opposes most of the prepayment plans linked with group practice.

#### **Development of Enabling Legislation in New York State (Article IX-C, Insurance Law), with Additional References to such Legislation in other States<sup>15</sup>**

"Preliminary recommendation Number 10" of the New York State Temporary Legislative Commission to Formulate a Long Range State Health Program was as follows:

"Immediate revision of the State Insurance Law to permit and encourage sound and well-planned voluntary health and medical care insurance schemes as well as expansion of voluntary hospital service insurance with ample provisions for record-keeping, and current analyses to provide actuarial data directly related to the individual health needs, met by the voluntary insurance schemes,

<sup>15</sup> See Part IV, Addenda on page 391.



in New York State, as one of the bases for the formulation of a long range health program for the State.”<sup>16</sup>

In New York State the first practical and widespread application of the principle of non-profit voluntary health insurance was put into statutory form by the enactment of Article IX-C of the revised insurance law of the State of New York. This Article IX-C, which in its final form was entitled “Article IX-C—Non-profit Medical Indemnity or Hospital Service Corporation,” was part of the entire revision of the Insurance Law. It has had a rather interesting history.

When the committee assisting the Superintendent of Insurance issued its tentative draft of the proposed revised law in 1937, it contained therein a section called IX-C, which was entitled “Non-profit Health Service or Hospital Service Corporation.” In the defining clauses of the said proposed law it was provided that:

“A membership corporation may be organized under the membership corporations law, and a consumers cooperative stock corporation may be organized under Article Seven of the cooperative corporations law for the sole purpose of furnishing health service to persons who become subscribers under contracts with such corporations. Such health service shall consist of medical care provided through duly licensed physicians employed by such corporation, or with whom such corporation contracts for the furnishing of such care and may include (a) hospitalization and nursing care, drugs and medicines, optical and surgical appliances and any other medical and surgical services and supplies necessary in the course of such medical care; and (b) dental care through duly licensed dentists employed by such corporation or with whom such corporation contracts for the furnishing of such care. Such dental care may include the furnishing of dental appliances, drugs and medicines and other dental supplies.” (Insurance Law Revision of the State of New York, Tentative Draft 1937 prepared by the Insurance Department of New York, Article IX-C, Section 79, Subdivision 1, page 279.)

This preliminary draft it will be noted provided for the broadest type of health service insurance plan on a voluntary prepayment basis and provided for the distribution of medical, hospital and dental care through the one corporation on either a fee-for-service or a contractual service plan.

In 1938 the draft of this bill was changed and Article IX-C was titled “Non-Profit Medical Indemnity, Dental Indemnity or Hospital Service Corporation.” This proposed bill provided that the corporation organized was permitted to furnish no more than one type of medical care, that is the one corporation could supply either hospital service, medical service or dental care. In this draft the idea of medical indemnity was introduced with the desire to main-

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<sup>16</sup> Preliminary Report of the New York State Temporary Legislative Commission to Formulate a Long Range State Health Program, Legislative Document (1939) No. 97, page 5.

tain the fee for service basis of reimbursement for physicians rendering care under such a plan.

After another revision Article IX-C was finally enacted into law in 1939 with the omission of dental indemnity in the following phraseology:

“Section IX-C—Non-profit Medical Indemnity or Hospital Service Corporation. Section 250, Subdivision 1. A membership corporation may be organized under the membership corporations law, and a consumers cooperative stock corporation may be organized under Article Seven of the cooperative corporation law, for the purpose of furnishing medical expense indemnity, or hospital service to persons who become subscribers under contracts with such corporations; medical expense indemnity shall consist of reimbursement for medical care provided through duly licensed physicians, for nursing service and of furnishing necessary appliances, drugs, medicines and supplies. Every such plan shall be open to the participation of duly licensed physicians without discrimination against schools of medical practice defined in the Education Law.” (Revised Insurance Law, Chapter 882, Laws of 1939.)

In the present stages of public interest in various methods which may lead to a more equitable distribution of medical care on a voluntary prepayment basis, the problem of the technique of the development of such a plan has become of paramount importance to the community in general.

Medical expense indemnity corporations under the new law can only solicit and enter into contract with subscribers after they have obtained from the Superintendent of Insurance a permit to do so. The application submitted for this permit includes a statement of the territory in which the corporation will operate, which shall not exceed 18 counties in this State, the services to be rendered by the corporations and the rates to be charged therefor. Copies of the contracts for the service which the corporation proposes to render to subscribers, as well as copies of the underwriting physician's contract, must be submitted for approval.

Before issuing the final license for the corporation to do business, the Superintendent of Insurance may make such examination and investigation which he may deem necessary, including investigation of the sponsors of said proposed corporation, and if after investigation he determines the issuance of such license is contrary to the interest of the people, he shall refuse to issue it.

The new law provides that no medical expense indemnity corporation can during any one year disburse more than 10 percent of the aggregate amount of the payments received from subscribers as expenditures for soliciting business except that during the first year after the issuance of the permit the corporation may disburse not more than 20 percent of the amount, and during the second year not more than 15 percent.

The law further provides that the corporation may not disburse more than 20 percent of its payments from subscribers during that year as administrative expense.

Under section 11, subdivision 1-b, of the Membership Corporations Law, the certificate of incorporation of a non-profit medical indemnity plan must be approved by the State Board of Social Welfare. This Board has laid down (Oct. 24, 1939) the following rules for the approval of medical indemnity plans.

"The consent of the State Department of Social Welfare to a certificate of incorporation which specifies among its purposes the establishment, maintenance and operation of a medical indemnity plan as permitted under Article IX-C of the Insurance Law shall not be granted unless:

A. The members of the board of directors shall be of such experience and standing as to give assurance of their ability to conduct the affairs of the corporation in its best interests and the interests of its subscribers; and

B. Such certificate provides:

1. Of the members of the board of directors at least one-third shall be persons other than physicians and at least one-third shall be physicians duly licensed to practice in the State of New York.

2. The board of directors shall have one member for each one hundred thousand of population in the territory in which the corporation is authorized to operate, but not less than six nor more than twenty-four.

3. The plan shall be open to the participation of every duly licensed physician in the territory to be served.

4. There shall be free choice by subscribers of physicians admitted to such plans subject to:

(a) The acceptance of patients by the physicians, and

(b) Rules which the corporation may adopt to regulate the professional activities of participating physicians.

Nothing in these rules shall be construed to limit the power of a corporation to which such rules apply, from establishing conditions of participation of every duly licensed physician in the territory to be served and from providing appropriate measures of discipline for breaches thereof."

On February 2, 1940, applications had been made through the Board of Social Welfare for the approval of seven proposed certificates of incorporation for medical expense indemnity corporations being formed under Article IX-C of the Insurance Law. Four of the certificates had been approved and two had not been approved, and one was still being considered. The two that were not approved failed for such approval because they were not in accordance with the standards of the Department of Social Welfare as described above. The Department of Social Welfare exercises no supervision over medical expense indemnity plans except the approval of the certificate of incorporation required under the Membership Corporations Law. It will thus be noted that the supervision begins and ends with the approval of the certificate and what happens



thereafter is not within the province of the Department of Social Welfare. Furthermore, such approval is not necessary if a cooperative incorporates under Article VII of the Consumers Cooperative Corporation Law.

*Progress under IX-C:* The following three plans had been licensed by the Superintendent of the State Insurance Department before this report was submitted:

- A. Medical and Surgical Care, Inc., Utica, New York.
- B. Associated Health Foundation, Inc., New York City.
- C. Western New York Medical Plan, Inc., Buffalo, New York.
- D. Medical Expense Fund of New York, Inc., Brooklyn, New York.

On questions of general policy, the Superintendent of Insurance considers the problems individually as applications are made. Due to the lack of actuarial data in this field the department is insisting that each plan insert in its contract with the doctor a provision somewhat as follows: In the event that the plan may not be self-sustaining during periods of epidemics or other contingency, and in order that the corporation may keep faith with the subscribers by providing the benefits subscribed for, the underwriting member shall furnish such services to the subscribers during the contract period, when and as necessary, regardless of the corporation's ability to pay. In such event it is expressly agreed that the liability of the corporation for such services rendered by the underwriting member shall be contingent upon its ability to pay.

Article IX-C in its broad interpretation allows for the organization of a non-profit corporation to provide medical or hospital expense, or indemnity to subscribers with reimbursement to physicians for medical care services on a fee for service or per capita basis. The law at present limits the experimental field in medical care plans from two broad points of view:

1. A corporation cannot be organized to provide both medical care expense indemnity and hospital care expense indemnity.

2. Article IX-C, Section 250, provides that every such plan shall be open to the participation of duly licensed physicians without discrimination against the schools of medical practice defined in the Education Law.

This is interpreted as prohibiting the licensing of medical service plans whose subscribers are to be serviced by a closed and selected group of physicians. Despite the limitations of the present statutes, in New York State as well as other states, there have been developed medical care plans operated on the basis of group practice and financed by prepayments as well as fees for service.

There are medical care organizations which do not operate under the supervision of the State Insurance Department and the Department of Social Welfare, as provided for under Article IX-C of the Insurance Law and the Membership Corporations Law, as well as Article 7 of the Cooperative Association Law.



Enabling acts for medical care corporations on a non-profit basis were passed during the 1939 legislative session in the states of Michigan, Connecticut, Pennsylvania and New York. In at least 11 other states similar bills were introduced. The laws passed so far have considerable similarity. However, it is only in the New York State statute that the term "Medical Expense Indemnity" is used. The statutes in the other states simply refer to the furnishing of medical service to subscribers under contracts, entitling the subscriber to such service at the expense of the corporation. It should be noted that only one state, Pennsylvania, provides for supervision by the Department of Health, with regard to quality of the medical care furnished to subscribers.

### Description of New Forms of Medical Service

The first part of this section describes a number of recent experiments in organizing the provision of medical care along lines different from the traditional system of individual practice and payment.

*Example 1:* refers to a plan which provides only diagnostic services, and is organized and administered by a group of physicians, and financed by charging an all-inclusive flat fee.

*Example 2:* refers to an attempt made by a union to provide for preventive services and to expand its activities to curative services.

*Example 3:* shows a medical care program offering a variety of services, conducted on the basis of group practice and financed by both prepayments and fixed fees for service.

*Example 4:* deals with a complete medical care program, conducted on the basis of group practice and financed by an industrial corporation.

*Example 5:* presents a summary of available experience in a condensed report on five medical care programs studied in operation during the years 1939 and 1940.

The second part of this section describes a number of plans which provide for "cash indemnity" or the reimbursement of physicians for medical and surgical services rendered to subscribers on the basis of individual practice. All these plans have been licensed for operation in New York State. The premiums to be paid by the subscribers entitle them to physicians' care only.

*Examples of Group Practice:* 1. Diagnostic service, organized and administered by a group of physicians, financed on the basis of an all-inclusive flat fee: Mount Sinai Hospital, New York City. This consultation diagnostic service was established in 1932 as an experiment in placing the professional and physical facilities of the Mount Sinai Hospital at the disposal of the practicing physicians of the community for the study of obscure or complicated diagnostic problems among their patients of moderate means. It is an independent, detached unit of the hospital, not a part of the out-

patient department. A patient must be referred by his physician, and admission is granted only to patients with incomes of less than \$4,000 per year.

The work is limited exclusively to diagnosis. A flat fee of \$35 is charged for every patient regardless of the nature of his illness or the number of consultations or laboratory examinations required. A report of the findings, together with suggestions for treatment, is forwarded to the patient's private physician upon the completion of the diagnostic work-up.

2. The Union Health Center, New York City. Several local units of the International Ladies Garment Workers Union inaugurated a cash benefit system for sickness about the year 1913.

In 1913 a group of labor unions in New York City joined forces to establish a low price dental clinic, known as the Union Health Center.

In 1928 the service was expanded by the addition of medical care. A clinic of six doctors was established, with facilities for health examinations and medical treatment for members of the union.

The Union Health Center derives its income partly from the unions whose members use its facilities and partly from the patients themselves. Some local units operate benefit systems and pay for all the medical care extended to their members, for examination of applicants prior to their acceptance as members, and for home visits, if and when members are unable to come to the Center. The members who do not come under this heading but wish to secure medical care at the Union Health Center pay nominal fees, generally \$1.

Since May, 1934, the International Ladies Garment Workers Union has assumed full responsibility for the finances of the Union Health Center. This union in New York City alone has a membership of more than 100,000 men and women.

3. Medical Care Program, conducted on the basis of group practice and financed by both prepayments and fees for service. Ross-Loos Medical Group, Los Angeles, Cal.<sup>17</sup>

The Ross-Loos Medical Group was originally organized in 1929 in Los Angeles, Cal., to render medical service to the employees of the Department of Water and Power of the city. The service was expanded when contracts for service were signed with other employed groups, and in 1936 the Group leased a four-story building to house the growing clinic.

Financial and professional arrangements between the clinic and groups of subscribers are negotiated by specially organized health committees. At the present time, there are approximately 21,000 employed subscribers representing more than 110 different groups of persons, constituting with their families more than 60,000 people.

The Group is owned and operated by a medical partnership of 19 of the 69 full-time staff physicians. The staff has its offices

<sup>17</sup> Law and Contemporary Problems, Medical Care, School of Law, Duke University, Vol. VI, Autumn, 1939, No. 4.

either in the main clinic or in one of the 10 branch clinics located in the suburbs. The facilities have been specially designed for the particular type of practice engaged in.

For \$2.50 per month under the group enrollment plan<sup>18</sup> the clinic agrees to provide for the subscriber medical services of general practitioners, specialists and surgeons in the home, clinic or hospital. Services also include laboratory work, x-ray services, physical therapy treatments, eye refractions, drugs and dressings, and hospitalization. Dependents of members may receive all professional services at 50 cents each for office call, \$1 for each resident call and other small charges for special procedures, such as \$25 for a major operation. The average charges for service to dependents is 81 cents per month per family. The average of 15.8 office calls (excluding calls for operative procedures) per year per average family of 3.2 persons indicates the volume of service rendered.

4. Medical Care Program, conducted on the basis of group practice by an industrial corporation.

The program sponsored by a big industrial company as one of a variety of its general welfare activities, serves the employees of the plant and their family dependents, totalling about 51,000 persons in 1938. The program is all-inclusive and operated without any restriction. Type, scope, amount and quality of medical care meet high standards. In the year 1937-38 the total costs of the medical care program, excluding money value of rent, cost of administration, taxes, and depreciation, averaged \$17.40 per person eligible for service. The adjusted costs, covering the aforementioned items and excluding depreciation, may be estimated as ranging from \$20.50 to \$21.80 per eligible person and year. The costs of hospitalization were \$7.55 per person and \$74 per hospitalized case. The costs of drugs were \$1.76 and \$1.98 per person, excluding and including pharmacists' salaries; the average cost of an order filled at the pharmacies was 35 cents. The expenditure for hospital care accounted for about one-third of the total (adjusted), that for drug supply for about 9 percent, including the salaries of the pharmacists.

This program indicates that medical care, adequate both in quantity and quality, may be furnished at reasonable average costs provided the risks are spread among large groups of people. It is claimed that, under these conditions, a reasonable average expenditure can buy more services than are offered and at lower rates than are actually charged by many plans which are now in process of development. However, consideration should be given to the intangible factors involved, on which opinion of experts is divided.

#### 5. Summary of a study of five medical care plans.<sup>19</sup>

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<sup>18</sup> Individuals may now subscribe on a non-group basis for service at \$3 per month premium.

<sup>19</sup> Condensed from Goldmann, Franz, M.D., Costs of Group Health Service. A comparative study of five plans of organized medical care for self-supporting people.



During the years 1939 and 1940 five established medical care programs operating in different parts of the country were studied in detail. All of them use group practice to furnish medical services varying in type and scope. All of these programs operate around central clinics. The programs differ, however, in the ways they are financed. Two plans operate exclusively on prepayments, two use prepayments in combination with certain payments on a fee-for-service basis, and one, operated by an industrial corporation, provides medical care free of charge to employees and their dependents.

The two prepayment plans provide services of nearly the same type, scope and amount, covering general physicians' care, as well as certain specialists' services; clinical laboratory, roentgenological and physical therapy services; and hospitalization subject to certain restrictions. There are a few variations primarily in the volume of available services. Furthermore, there are special arrangements for the subscribers to purchase at low prices drugs and certain appliances as prescribed by the physicians. The average costs of these two programs range between \$12 and \$30 per eligible person and year, including all expenses except an estimate for depreciation of plant and equipment.

Two other plans offer approximately the same fundamental services as described above with the exception of hospital care and a few special services. In both instances hospital care constitutes an additional expense to be borne directly by the patient himself. There are special low price arrangements for certain types of medical care such as treatment with x-ray and radium, and limited dental care, both to be paid for by the patients. The average cost per person under one of these plans which serves subscribers to the prepayment plan as well as fee-for-service patients, is in the neighborhood of \$28 per year. No reliable rates could be computed for the second plan in this group.

The fifth plan provides for medical care of the widest range, including every kind of specialists' services; dental care with the exception of dentures and gold work; all drugs prescribed; and, hospitalization without restriction. This program costs about \$21 per eligible person per year.

The striking differences in the costs of these plans appear to be due primarily to three factors:

First, the services of the programs with relatively higher costs are sought for most part by people who are eager to avail themselves of the facilities offered at favorable terms. The subscribers are adversely selected "risks" because people actually in little need of service do not join in a sufficiently large number. The groups covered by these plans represent only a small fraction of all the people living in the respective areas. On the other hand the plans operating on an average per capita cost of \$21 and \$12, respectively, are organized for service to cross-sections of a certain economic, occupational, and social class constituting a substantial proportion of the population in the respective communities. The differences



in their costs are mainly due to variations in scope and amount of services.

Second, the uneven spread of risks under the one group of plans as contrasted to the fair distribution of risks prevailing under the other, results in quite different demands for service and wide variations in the number of physicians needed.

Third, the size of the various groups covered ranges from approximately 5,000 to more than 50,000.

All the plans investigated show a definite trend to decrease in per capita cost when the number of people covered increases. Furthermore, the average cost of the all-inclusive program for large unselected population groups is lower than that of the limited programs for small selected groups.

*Examples of Individual Practice:* 6. Medical and Surgical Care, Inc., Utica, N. Y.

Area to be served: Territory covered by the counties of Oneida, Herkimer, Madison, Lewis, Otsego, Chenango, Montgomery, Fulton, St. Lawrence, Franklin, Essex and Clinton. This corporation proposes to issue contracts to groups of subscribers on a payroll deduction basis, with no limitation to income. Two plans are offered.

*Rates:*

A—Sixteen dollars and eighty cents per year for gainfully employed persons. No married woman residing with her husband shall be covered unless her husband is also enrolled.

B—Thirteen dollars and eighty cents per year for spouse of subscriber and unmarried dependent children of subscriber between ages of 16 and 18.

C—Eight dollars and forty cents per year for all the dependent children of the subscriber between the ages of 1 and 16 years. Under this plan for a family of husband and wife, one 17 year old child, one 15 year old child and one 14 year old child, total of five, the annual charge would be \$52.80.

*Deductible Features:*

The first \$6 of the expense of illness, examination or treatment of the subscriber or dependent during the contract year, shall be paid to the physician by the subscriber or the dependent, and the expense of the first two calls on the subscriber or dependent in each illness made any place other than a hospital shall be paid by the subscriber or dependent.

*Limitations:* It is proposed that the limitations for indemnity will be:

A—Two hundred and twenty-five dollars for any one person.

B—Three hundred and twenty-five dollars for any two persons.

C—Four hundred and twenty-five dollars for any three or more persons.

*Medical Benefit Exclusions:* No medical expense reimbursement is covered by the following conditions:

- A—Pregnancy occurring within 10 months.
- B—Workmen's compensation cases.
- C—Hernia and tonsil operations within 10 months of the date of execution of the contract.
- D—Drugs.
- E—Eye glasses.
- F—Care of teeth.
- G—Blood transfusion.
- H—Any condition, disease or ailment, existing at the time of the subscriber's application.
- I—Service to any subscriber who had had prior to or at the time of application the following diseases:

Cancer	Chronic nephritis
Diabetes	Coronary thrombosis
Osteomyelitis	Pernicious anemia
Tuberculosis	Insanity

*Reimbursement of Physicians:* The doctors under this plan will be paid on a fee basis on a schedule based on the workmen's compensation fee schedule. Doctors agree to accept a pro rata share of income if funds are not sufficient to pay in full.

A second plan is contemplated with reduced premiums and increased deductible features.

#### 7. Western New York Medical Plan, Inc., Buffalo, New York.

Area to be served—Counties of Allegany, Cattaraugus, Chautauqua, Genesee, Niagara, Orleans, Erie and Wyoming. This corporation proposes to issue contracts to groups of subscribers on a payroll deduction basis, with membership limited to those earning less than \$1,800 for an individual, \$2,500 for man and wife and \$3,000 for family.

#### *Rates:*

- A—Individual subscriber \$18 per year.
- B—Man and wife \$27 per year.
- C—Full family coverage, man and wife and all unmarried children under 19 years of age, \$36 per year.

*Benefit Deductions:* This plan has a deductible feature inasmuch as the subscriber must pay the physician for one-half of the fees amounting to a total of the first \$20.00, in non-surgical cases and for house and office calls in any contract year. The purpose of this clause is to prevent the subscriber from going to the physician for inconsequential matters.

#### *Medical Indemnity Limits:*

- A—For the individual subscriber \$200 for one year.
- B—Man and woman \$300 for one year.
- C—Full family coverage \$400 for one year.

*Medical Benefits Exclusions:*

- A—Workmen's compensation cases.
- B—Elective operations for the first year of contract.
- C—Venereal diseases during the first 11 months of the contract.
- D—Any ailment arising from the use of drugs and alcohol.
- E—All functional nerve and mental diseases in excess of \$50.
- F—Obstetrical service during the first year of contract and extra specialist fees above \$50 per confinement after the first year.
- G—Services rendered during diagnostic investigation or study founded on definite evidence of disease or injury.
- H—Treatment of congenital diseases.
- I—Services rendered for any ailment known to exist prior to the date of application.
- J—Injury or diseases contracted in the commission of felony.
- K—Intentional self-inflicted injuries.
- L—Services to individuals who have had prior to application the following:

Cancer	Tuberculosis
Diabetes	Chronic nephritis
Osteomyelitis	Coronary thrombosis

*Reimbursement of Physicians:* This plan expects to pay doctors on a fee basis, with the doctors agreeing to accept a pro rata share of income if funds are insufficient to pay in accordance with fee schedule.

8. Associated Health Foundation, Inc., New York City.

*Area To Be Served:* The counties of New York, Bronx, Queens and Kings.

This corporation plans to issue contracts to cover all medical care without any limitation as to the total amount that may be required and without any deductible features. Membership in this plan is not limited to any income class group.

*Rates:*

A—Individual subscribers \$18 plus \$1 annual fee for the first year.

B—Adult and spouse \$30 plus \$1 annual fee for the first year.

C—Child under 16 years of age \$7.50 plus \$1 annual fee for the first year.

D—Child over 16 and under 18 years of age \$12 plus \$1 annual fee for the first year.

Under this plan for a family of husband and wife, one 17 year old child, one 15 year old child and one 14 year old child, total of five, the charge would be \$48.

*Medical Benefit Exclusions:*

- A—Workmen's compensation cases.
- B—The elective operations for the first 11 months of the contract.



C—Any condition arising from pregnancy and childbirth during the first 10 months of the contract.

D—Any condition due to drug addiction or chronic alcoholism.

E—All functional and nervous diseases.

F—Services Rendered Subscribers:

(1) Who have had prior to or at the time of application the following diseases:

Insanity

Pernicious anemia

Cancer

Diabetes

Tuberculosis

Chronic nephritis

Osteomyelitis

Chronic heart disease

Psoriasis or any incurable skin disease.

(2) For any condition, disease or ailment existing at the time of the subscriber's application.

G—Services rendered in treatment of venereal diseases for the first 10 months of the contract.

H—Services rendered in the treatment of congenital diseases.

I—Services for plastic or cosmetic surgery.

J—Hospital or nursing service.

K—Drugs, medicines or surgical supplies.

*Reimbursement of Physicians:* This plan expects to pay doctors on a capitation basis. The physician receives a set fee for each person under his care for a given period regardless of the amount of service rendered. Sixty percent of the funds are to general practitioners and 40 percent to specialists, surgical, etc. Payment is to be made out of earned income less administrative costs and reserves.

The Utica and Buffalo plans are to be operated on a medical expense indemnity basis with reimbursement of the physicians on a fee-for-service agreement. The Associated Health Foundation, Inc., is to operate on a per capita payment system to the physicians rendering services to subscribers.

The Superintendent of Insurance has informed the Commission that they are interpreting Section 250 of Article IX-C of the Insurance Law in its broad sense to allow for the organization of medical expense indemnity corporations reimbursing physicians for the services to subscribers on a per capita basis as well as a fee-for-service basis.

*Comments on Plans Established under Article IX-C, Insurance Law.*—Some of the medical expense indemnity plans established under Article IX-C of the New York State Insurance Law have adopted policies which are similar to those followed by commercial insurance.

*Age Limitation.*—Commercial—and fraternal—accident and health insurance policies have safeguarded to some extent their risk through limitations on the issuance of holding of policies to



the extreme young and older age groups. It is obvious from this standpoint that the security against sickness for the general population is not complete. The plans under development under Article IX-C are also utilizing this age limitation clause in decreasing their insurance risk.

*Limitations on Medical Service.*—In keeping with the procedure of the commercial—and fraternal—health insurance organizations, the newly developed plans under Article IX-C have introduced clauses in their policies which exclude from service pre-existing conditions and conditions which exist within a certain defined waiting period. Additional restrictions exclude care of certain diseases such as tuberculosis, cancer, mental and nervous disorders, as well as conditions covered under the Workmen's Compensation Act.

*Deductible Clause.*—Two of the plans established under Article IX-C make use of so-called deductible clauses. Patients have to pay directly the first \$6 (Utica) or \$10 (Buffalo) of their physician's bill during the contract year, under the Utica plan the first two calls of each separate illness during the second and succeeding years would be non-reimbursable. (A similar policy is followed by the "Columbia Medical Society Mutual Health Association," Washington, D. C., which requires patients to pay for the first \$5 worth of service in each year.) From the standpoint of a general long range health program this clause is detrimental to the idea of prevention. People are discouraged from seeking important preventive services such as periodic physical examinations and immunizations, and may hesitate to ask for advice, examination or treatment in early stages of illness or doubtful ailments.

The deductible clause must be considered in connection with two facts: first, there are additional costs to the patient, such as care of diseases excluded from service, night calls, hospitalization and drugs; second, there is often a maximum annual indemnity in proportion to the size of prepayments.

*Waiting Period.*—In the development of premium schedules for the health policies sold by insurance companies and fraternal organizations, the use of a waiting period has materially affected the amount of annual premium.

A representative policy may have a premium rate of \$29.28 when the waiting period is three months and a premium rate of \$73.20 when the waiting period before eligibility for benefits is reduced to less than one day.

*Cancellable or Non-renewable Clause.*—A cancellable or a non-renewable clause which is present in a great many of the commercial and fraternal insurance policies is of decided protective value to the insurance carrier in decreasing the risk involved in writing such insurance. From the standpoint of the public this has decided disadvantages, since a policyholder cannot be sure of protection throughout his working lifetime.

### Achievements and Shortcomings of Voluntary Health Insurance

The various efforts to develop voluntary health insurance deserve high commendation. "The proof of their value, however, is not their good intentions" but a careful examination of their actual accomplishment and future prospects.

*Coverage.*—Both the economic and occupational status of the people actually covered by the various voluntary health insurance plans in operation can be fairly well described. The majority of the people who have enrolled in group hospital plans belong to families with moderate incomes. A study conducted by the Associated Hospital Service of New York demonstrates that "80 percent of the subscribers to this plan not only in New York, but in other parts of the State even more, have incomes of less than \$2,500 a year. This indicates that this plan does meet its original purpose of serving the person of modest income. The group enrollment regulations under this plan provide that those persons who earn less than \$1000 a year be excluded from enrollment requirements. While such persons are not debarred from enrollment, they are not urged to do so because generally such persons are unable to obtain the services of a personal physician and consequently represent the segment of the population which should receive free services in the hospitals and from the medical profession." <sup>20</sup>

Occupationally most of the subscribers are either high-paid skilled workers or white-collar workers and professional people. It is important to note that often the family, rather than just the wage earner, has made use of the offer to subscribe.

The services of prepayment plans conducted on the basis of group practice are primarily sought by families with incomes above \$1,500 and below \$3,000. The percentage of families with lower incomes is relatively small.

There is no accurate information as to the economic condition of people subscribing to cash indemnity plans. However, it seems fair to assume that few subscribers to cash indemnity plans would come from low income groups.

The total number of persons actually covered by various plans can be estimated only very roughly. Group Hospital Plans have reached approximately 4½ million people in this country. Prepayment plans for medical care, offering physicians' care or a variety of services to the general public, probably serve a few hundred thousand persons. Medical care programs, operated for employees of industrial or business firms and financed either by employers or employees, may cover a few million persons. Furthermore, about 8 million wage earners may carry some form of insurance against temporary disability with private insurance companies, and a larger number of industrial insurance policies is in force covering death or permanent disability.

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<sup>20</sup> Pp. 658-659 Report of the Public Hearing N. Y. S. Temporary Leg. Commission, Dec. 15-16, 1938.

It is claimed that voluntary insurance against the economic risks of illness is primarily used by people who are fortunate enough to enjoy such an income as to permit savings including prepayments for some protection from illness.

Some students of the subject believe that on the basis of actual experience in this country<sup>21</sup> three factors appear to have had decisive bearing on the enrollment by the general public in prepayment plans. First, many people "preferred taking a chance to budgeting ahead because they relied on their previous good health record." Second, "there was—and still continues to be—a big turnover of subscribers; the result was concentration of persons in ill-health and loss of persons in good health," with the implication of uneven spread of risks and relatively high average costs to many plans. Third, people interested in budgeting for medical care saw no profit in many of these propositions because the "premiums" were disproportionate to the value of the services offered.

*Scope of Service.*—Commercial insurance policies offer some protection from economic distress by reimbursing policyholders in the event of accident, sickness, disability and death. However, often the policies are so restricted as to cover only fractions of the wages lost. The reports received by this Commission from insurance companies writing group accident and health policies confirm the findings made by the Illinois Health Insurance Commission about 20 years ago. Although 25 percent of the wage earners examined in 1919 were found to be insured by group accident and health policies against loss of wages, only 13 percent of those who lost wages for one week or longer received compensation for a part of their losses, and only 6 percent of the total wages lost were recovered.

The development of non-profit plans for hospital care is highly significant and important. Experience shows that patients, hospitals and physicians are benefited. However, there remains the fact that for the patient and the community existing group hospital plans meet only a part of the need because payment for the services of physicians as well as hospitalization for socially important diseases of conditions are excluded from service.

*Prepayment Plans for Medical Care.*—Organizations established on this basis have attempted to make contributions to the solution of the medical care problem by providing for the large variety of services necessary to restore and maintain health. They are based on both the individual and group practice of medicine. However there are frequent restrictions as to type of illness or type of service covered under the prepayment arrangements. If a problem exists for providing good medical care, both in quality and quantity, existing experimental plans are too small in number to be a decisive factor in community health programs.

Few prepayment plans for medical care, conducted on the basis of individual practice, are actually in operation. Article IX-C of

<sup>21</sup> Goldmann, F., Costs of Group Health Service. A comparative study of five plans of organized medical care for self-supporting people.



the State Insurance Law provides for prepayment plans conducted on the basis of individual practice, and plans proposed reveal certain facts relating to scope of service. Not only is service restricted to physicians' care, but physicians' care is incompletely covered. The "deductible clause," used in a number of "cash indemnity" plans, tends to inhibit the practice of preventive medicine, and the long list of diseases exempted from indemnity greatly decreases the potential value of such service.

*Costs.*—Commercial insurance companies offer individual or group insurance at rates beyond the reach of people in low income groups. Often the premiums represent more than 5 percent of the worker's income yet entitle him to only limited reimbursement.

Non-profit plans for hospital care charge fees from 50 to 85 cents per month per individual or from \$1 to \$2 per month per family. Dr. I. S. Goldwater, Commissioner of Hospitals of the City of New York, in testifying at the public hearing<sup>22</sup> before this Commission, stated:

"I believe people earning \$1,500 or more who are regularly employed could help themselves out so far as hospital service is concerned, by joining these insurance plans. I believe there are many families with an income of \$1,200 to \$1,500 who have no money for hospital care and who are entitled to get it."

This statement clearly indicates that the burden of prepayments for hospital care is too heavy for individuals comprising large groups of the population. It has been suggested by some experts that these prepayment plans be extended to include hospital care on a ward basis.

Proponents of voluntary health insurance feel that under any acceptable plan both hospital and medical care should be furnished. Since the nonprofit hospital plans have already had considerable experience their rates may be taken as a standard for hospital care. To these rates for group hospital plans we have to add all the other expenses of sickness to be borne by the patient. Under the incorporated non-profit medical expense indemnity plans in this State there would be additional costs of \$16.80 to \$18 for a single subscriber, bringing the total near to \$28. For a family with two children under 16 years the various plans would require prepayments for physicians' care ranging from \$36 to \$45, bringing the total up to \$60-\$69. Even this expenditure, however, would not guarantee complete medical care; the patient would have to pay extra for the respective amounts excluded by the deductible clause, treatment of illnesses not covered by the contract, drugs and appliances, dental services, bedside nursing at home and in some instances even night calls. The total annual cost of both hospital care and medical indemnity under some proposed plans might be so high that it would be prohibitive for the great mass of the population.

<sup>22</sup> Minutes of the Public Hearing, N. Y. State Temporary Leg. Commission to Formulate a Health Program, Dec. 13, 1938, Vol. I, p. 30.



Proponents of group practice claim that the total average costs of medical care under prepayment plans combined with group practice range from about \$12 to approximately \$30 per eligible person per year. This figure includes all expenses to the patient for physicians' care by both general practitioner and specialists, dentists' services, laboratory services, diagnostic and therapeutic x-ray services, physical therapy services, drugs and some appliances, hospitalization—subject to restrictions—ambulance service and bedside nursing at home. It is claimed that an average of \$20 to \$22 per eligible person and year appears to be necessary to operate an all-inclusive prepayment plan for groups of people, and a lower rate to furnish all the necessary "fundamental" services subject to certain restrictions. However, it seems this can be done only if group practice is used and large unselected population groups are covered. The practicability of interesting such large unselected population groups in suitable coverage may well be questioned. The answer will probably be found in the future experience with voluntary plans.

*Administration.*—There are prepayment plans which are administered by physicians only. Others are operated solely by the consumers or subscribers. The democratic principle of self-government requires that responsibility for administration is shared by all groups concerned. In other words, both physicians and potential patients should be represented adequately on a board of trustees. Many prepayment plans have by-laws defining the spheres of influence of laymen. A typical example of such a by-law is the following:

"The Board of Trustees shall in no way regulate or supervise the practice of medicine by any physician with whom it arranges for the care of members, nor shall it in any way supervise, regulate, or interfere with the usual professional relationship between such physician and his patient member, and every such agreement entered into by and between a physician and the Association shall contain a positive covenant to that effect."

However, under any plans, proposals involving medical policy should be developed only with the advice and guidance of qualified physicians.

*Standardization.*—Central guidance and standardization is imperative to avoid waste of efforts and money. The American Hospital Association by issuing "Essentials of an Acceptable Plan of Group Hospitalization" in 1933 and by establishing a "Council on Hospital Service Plans" in 1938, has taken important steps to coordinate the movement towards plans for hospital care.<sup>23</sup> The Bureau of Cooperative Medicine was founded in 1936 to give "instruction and advice on the organization of health associations by groups of people who wish to obtain medical service on a coopera-

<sup>23</sup> Approval Program and Standards, The Commission of Hospital Service, American Hospital Association, Second Revision, 1939.

tive basis." The Group Health Federation of America was founded in 1939 for the purpose of establishing and maintaining standards of practice and organization of group health plans. The American Medical Association is making studies of the various forms of voluntary health insurance prepayment plans now being organized by State and county medical societies, in many states, in order to compare them with respect to the extent to which they meet the need for improvement in the distribution of medical care.

*Supervision*—is still far from satisfactory. Bankruptcies obviously would discredit all efforts to develop voluntary health insurance. In addition, supervision as to quality of medical care appears to be an urgent necessity so as to prevent medical care programs from functioning unless they maintain proper standards. In most of the states, hospital plans are under the supervision of Departments of Insurance, and in some instances Departments of Health and Welfare also participate. In New York State supervision from the fiscal standpoint is maintained by the Superintendent of Insurance. In addition, the Certificate of Incorporation for non-profit medical care plans organized under the Membership Corporations Law must have the approval of the Department of Social Welfare.

*Legislation*.—At present insurance laws in many states do not allow experimentation with new forms of medical practice and new methods of finance. New York State has enacted enabling legislation for the formation of non-profit medical expense indemnity corporations. The law at present limits the experimental field in medical care programs by prohibiting, first, a combination of physicians' and hospital care under "expense indemnity" plans and, second, development of service plans conducted by a closed and selected group of physicians. Among proposals in other states the Wisconsin Bill seems to offer the widest possibilities for further experimentation.

Voluntary health insurance, as actually used on the commercial level as well as on a non-profit basis, should prove to be of value to those people who are not always in urgent economic need if sickness strikes them. However, these groups represent only a small proportion of the total population. It is fair to assume that most of the subscribers to voluntary plans have annual incomes exceeding \$1,500; probably the income groups over \$2,000 will be predominant in membership lists. But families and individuals with annual incomes from \$1,500 to \$3,000 represent only about one-fourth of the population. About one-third of the families and individuals are in the income brackets from \$750 to \$1,500, and approximately another one-third earn less than \$750. Unless drastic changes are made in voluntary health insurance plans and they are subsidized by the State or private charity, it is difficult to see how they can possibly meet the medical needs of persons earning less than \$1,500 per year.

Voluntary insurance against the economic risks of illness has been said to have "nowhere shown the possibility of reaching more

than a small fraction of those who need its protection.”<sup>24</sup> In 1932 a minority of the Committee on the Costs of Medical Care made the warning statement: “Voluntary insurance will never cover those who most need its protection. No legerdemain can bring into a voluntary system the unorganized, low paid working group who are not indigent but live on a minimum subsistence income. Yet any plan that helps those with less serious needs and does not reach those whose needs are sorest does not solve the fundamental problems of providing satisfactory medical service to all.”

Whatever may be done to fill the present gap, voluntary prepayment plans will still be needed. They are susceptible of certain expansion and ought to be developed—along sound lines and in a socially desirable direction. For the income groups able to subscribe these voluntary plans may furnish the solution to the problem created by the burden of unpredictable illness. There should be wide experimentation with all types of voluntary health insurance to determine the most suitable plans for different groups of the population—and how they can be integrated with existing public and private facilities for the distribution of medical care. Voluntary health insurance can contribute its share to a broad health program for all of the people; standing alone it cannot possibly solve the Nation’s health problems.

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<sup>24</sup> Report of the Technical Committee on Medical Care of the Interdepartmental Committee to Coordinate Health and Welfare Activities, Washington, D. C., 1938.



### PART III. COMPULSORY HEALTH INSURANCE

This summary of compulsory health insurance abroad gives a birdseye view of foreign developments. It is intended to describe common elements rather than details of national policies and laws. Because of this approach the presentation cannot possibly cover all aspects. However, stress is laid on such principles as are considered relevant to current American discussions on the subject. Several American authors have written excellent books which go into the details of foreign schemes, analyze their operation, and evaluate their achievements and shortcomings.

#### Characteristics of Required Programs as Contrasted to Voluntary Plans

There are three major points of distinction between required and voluntary health insurance programs.

First, under compulsory schemes, individuals are required to budget for their sickness costs instead of being free to join or leave a group serving mutual purposes. Second, under compulsory schemes individuals are required to put aside in advance small amounts of money to meet the burden of illness by regular pre-payments. Usually this is carried out by payroll deductions. The contributory principle may be applied only to the individuals to be served by the plan or extended to simultaneous inclusion of other groups, such as employers who are directly concerned. Third, under compulsory schemes government assumes responsibility for proper and sound legislation. Clearly defined rights are conferred on all people to whom the law applies, and the duties of the various groups concerned are set forth. Type, scope and amount of services and other benefits are determined and the details of financing arranged. Furthermore government reserves the right of supervising operation of the schemes as to compliance with laws and statutes and efficiency of performance. The theory of such a policy is that government requires self-supporting people to help themselves through what may be called "compulsory saving".

#### Attitude Toward "Compulsory Health Insurance" in the United States

The American movement for compulsory health insurance against the risks of illness dates back to 1913, when the First American Conference on Social Insurance was held in Chicago under the auspices of the American Association for Labor Legislation. In 1915 the American Association for Labor Legislation drafted a tentative bill. This "Standard Bill" became the basis for repeated attempts to advance required programs beyond the conversational stage. In 1919, Governor Smith of New York State referred to health insurance in his annual message by pointing out:

"Nothing is so devastating in the life of the worker's family as sickness. The incapacity of the wage-earner because of illness is

one of the underlying causes of poverty. Now the worker and his family bear this burden alone. The enactment of a Health Insurance Law which I strongly urge, will remedy this unfair condition. Moreover, it will result in greater precautions being taken to prevent illness and disease, and to eliminate the consequent waste to the State therefrom. It will lead to the adoption of wider measures of public health and hygiene, and it will operate to conserve human life. The large percentage of physical disability disclosed by the draft, shows how deeply concerned the State is in this matter. Proper provision also should be made for maternity insurance in the interest of posterity and of the race. Other countries are far ahead of us in this respect, and their experience has demonstrated the practical value and economic soundness of these principles."

However, steadily growing opposition united in a common front against "compulsory health insurance," such heterogenous groups as commercial insurance and fraternal orders, the drug industry and drug distributors, capital and labor, organized medicine and Christian Science. The movement came to a deadlock at the turn of the twenties.

The next phase is characterized by quite a different approach. Intensive searching, analyzing and finding of facts on needs and resources in the field of medical care had a commanding influence on this development. Among a great number of investigations, two attracted the widest attention: the studies conducted by the Committee on the Costs of Medical Care during the years 1928-32, and the National Health Survey conducted by the U. S. Public Health Service during the winter of 1935-36. These studies accumulated a tremendous volume of data on the social and economic aspects of medicine. Yet, the practical application of these data proved to be extremely difficult because of the magnitude of the problem and the multitude of its implications.

The Committee on the Costs of Medical Care, when trying to formulate recommendations for its final report, split over two major issues, namely group practice of medicine and group purchase of medical care. Still another split occurred when the question of choosing between compulsory and voluntary "health insurance" arose. Out of 50 members 11 recommended compulsory plans. Five other members disagreeing with the majority's preference for voluntary schemes, wanted at least experimentation with both methods. It was the findings of the National Health Survey that stimulated anew the efforts to adapt American medicine to the rapidly shifting social scheme.

A National Health Program, prepared by the "Technical Committee on Medical Care to the Interdepartmental Committee to Coordinate Health and Welfare Activities," was submitted to a National Health Conference, held at Washington in 1938. Of five recommendations "for meeting with reasonable adequacy existing deficiencies in the nation's health services" two referred to methods of protection against the financial burden and the economic insecurity which sickness creates for self-supporting persons. The report

continued: "No conclusion has emerged more regularly from studies on sickness costs than this: The costs of sickness are burdensome more because they fall unexpectedly and unevenly than because they are large in the aggregate for the Nation, or, on the average, for the individual family. Except in those years when unemployment is widely prevalent, sickness is commonly the leading cause of social and economic insecurity. Without great increase in total national expenditure, the burdens of sickness costs can be greatly reduced through appropriate devices to distribute these costs among groups of people and over periods of time."

The "Technical Committee" reported that it could not find the answer to the Nation's problem in voluntary insurance efforts. It reached the conclusion "that government must assume larger responsibilities than it has carried in the past if it is to help self-supporting people meet the problems of medical costs." According to the committee, the goal may be reached through the use of taxation, or through insurance, or through a combination of the two, preferably on a statewide basis. Public medical services and health insurance were methods recommended to be used as alternatives or in combination. The states would choose, develop, and administer the program which best fits their special conditions. The Federal government would furnish aid and assistance to the states. On this basis the Technical Committee recommended Federal grants-in-aid toward "approved classes of expenditures" made by the states in carrying out a more general medical program. In addition the Committee recommended Federal action toward the development of disability compensation on the basis of insurance against loss of wages during sickness, commenting as follows: "Such a program should preserve a high degree of flexibility, in order to allow for individual initiative, and for geographical variations in economic conditions, medical facilities, and governmental organization. It should provide continuing and increased incentives to the development and maintenance of high standards of professional preparation and professional service; it should apportion costs and timing of payments so as to reduce the burdens of medical costs and to remove the economic barriers which now militate against the receipt of adequate care."

The President, in his message to Congress on January 23, 1939, summarized the objectives and meaning of a National Health Program as follows:

"The objective of a National Health Program is to make available to all parts of our country and for all groups of our people the scientific knowledge and skill at our command to prevent and care for sickness and disability; to safeguard mothers, infants and children, and to offset through social insurance the loss of earnings among workers who are temporarily or permanently disabled. . . . The essence of the program is Federal-State cooperation. Federal legislation necessarily precedes, for it indicates the assistance which may be made available to the States in a cooperative program for the nation's health."



Subsequently, on February 28, 1939, the Wagner Bill (S. 1620) was introduced in Congress: "a bill to provide for the general welfare by enabling the several states to make more adequate provision for public health, prevention and control of disease, maternal and child health services, construction and maintenance of needed hospitals and health centers, care of the sick, disability insurance, and training of personnel; to amend the Social Security Act; and for other purposes." A subcommittee of the Committee on Education and Labor, U. S. Senate, early in 1940, reported favorably on the general objectives of this bill, at the same time admitting that revisions were necessary.

Meanwhile the American Federation of Labor had reversed its former attitude and, in 1935, adopted a resolution "urging the enactment of socially constructive health insurance legislation." In 1940 the American Association for Social Security offered a revision of its "Standard Bill," first published in 1934.

One attitude taken by organized medicine is revealed in the action of the California State Medical Society in 1933, when it formally endorsed the principle of compulsory insurance against sickness. A special state committee prepared a "Health Service Insurance Act," the first and only bill drafted by a medical organization. Later, support of the bill was withdrawn.

The Social Security Act, as first planned, was to cover three subjects: unemployment, old age, and medical care. However, planned provisions dealing with risks arising out of ill-health were dropped after consultation with a committee of 12 physicians.

In February, 1935, the House of Delegates of the American Medical Association had passed a resolution reaffirming "its opposition to all forms of compulsory sickness insurance whether administered by the Federal Government, the Governments of the individual States or by an individual industry or similar body." The Social Security Act was passed without provisions for medical care.

In 1937, a committee of physicians, later taking the name "Committee of Physicians for the Improvement of Medical Care, Inc." came out with "Principles and Proposals" in an effort to make constructive recommendations. In concluding a list of proposals the committee stated "health insurance alone does not offer a satisfactory solution on the basis of the principles and proposals enunciated above."

In 1938 the American Medical Association considered the National Health Program at an emergency meeting held at Chicago. The president, in his address pointed out: "the American Medical Association never has opposed the principle of insurance" and added: "It is not the principle of insurance that is opposed by American medicine. The principle which we do oppose is political administration and manipulation of the insurance organization, devotion of a considerable portion of the funds thus derived to the payment of a great number of employees not directly concerned with the service but intimately concerned with the maintenance of a political organization, and expansion of such organizations to wield greater and greater power in the affairs of the nation."

The American Medical Association approved not only the "principle of hospital insurance" and "voluntary indemnity insurance." They endorsed required insurance against loss of wages during sickness and expansion of workmen's compensation.

But they were "not willing to foster any system of compulsory health insurance." The American Medical Association was "... convinced that it (compulsory health insurance) is a complicated, bureaucratic system which has no place in a democratic state. It would undoubtedly set up a far-reaching tax system with great increase in the cost of government. That it would lend itself to political control and manipulation there is no doubt."

If the development were to take the course presupposed by the American Medical Association, compulsory program certainly would be most defective. Whether the evils feared by the American Medical Association are necessarily inherent in such a program is a question which cannot be brought to a decision without full knowledge of all the details of policy and procedure to be adopted. As the "Committee of Physicians for the Improvement of Medical Care" puts it: "Whether we are favorably inclined to the principle of compulsory health insurance, or not, it is the part of wisdom to establish in advance the general principles which should govern such projects."

### Principles and Trend of Development of "Compulsory Sickness Insurance" in Foreign Countries

*Reasons for the Development of Required Programs.*—Abroad one country after the other proceeded to establish sickness insurance plans. The factors determining the choice of compulsory sickness insurance were similar in many countries. They were stated to be the inadequacy of individual savings, public assistance, and voluntary health insurance. It was noted in many instances that the life's savings of an average family were wiped out by one serious illness, one major operation, one long hospitalization, one prolonged series of treatments. It was found that tax-supported medical care, in the form of public assistance, was not feasible for many self-supporting people. It was found that voluntary health insurance, while feasible for people in the middle income groups, could not reach the large self-supporting population groups within the lower income brackets. After lengthy experimentation with other methods, many countries in Europe, Asia, South America and Australia adopted compulsory plans, and no country ever abandoned such a policy. There was no relation between enactment of "compulsory sickness insurance" laws and the form of government.

*The Purpose of Compulsory Sickness Insurance Plans Abroad Has Been Three-fold*—(1) compensation for loss of earnings due to illness, non-industrial injury and maternity; (2) provision of medical care as necessary to restore good health; (3) preventive medical services for well persons. In its early days the function of sickness insurance was centered on prevention of the economic consequences

of ill-health. In the first phase of evolution most of the plans gave preference to the payment of "cash benefits" so as to compensate wage-earners for loss of wages due to disabling illness. In the second phase of evolution provision of medical services of various types was increasingly emphasized so as to prevent sickness from progressing into the chronic or incurable stage. In fact, in some countries sickness insurance plans became primarily a mechanism for the restoration and conservation of health by "benefits in kind." Provisions for early diagnosis and thorough treatment in an early stage took the place of provisions for disability compensation. In the third phase of development, more attention was given to preventive medicine including maternity care. The significance of this marked change in concept must be interpreted in relation to the American situation. Medical care in many foreign countries was organized on a curative basis with a large number of autonomous administrations which were difficult to adapt to the development of preventive services. A modern medical program should provide for a complete integration of preventive and curative services. Sickness insurance was designed to meet primarily needs of such sick people as could be covered by the program. Compulsory sickness insurance constituted one avenue to the goal of a national health program; being a method, rather than a panacea, it was always combined with other methods, such as voluntary insurance and tax support according to the needs of the various economic and occupational groups.

*Coverage.*—Every country adopting compulsory sickness insurance found it hard to draw a just and reasonable demarcation line between people who could and people who could not be covered by the program. There were, and still are, wide variations in scope of coverage in various countries—according to the prevailing needs. However, there are certain principles and trends common to many foreign programs. In broad terms eligibility for compulsory sickness insurance may be determined in either of three ways or in combination of all three: (1) by income regardless of type of occupation; (2) by type of occupation regardless of income; (3) by type of employment, such as industry, business, agriculture, domestic service. At their beginning, compulsory schemes were applied primarily to specified groups of wage-earners such as industrial workers. Later the prevailing philosophy was to extend the programs to many other occupational groups including office employees, white collar workers and other employees receiving salaries. This policy often was carried out by setting an upper income limit beyond which salaried employees were not required to join the scheme while "manual workers," because of the size of their average income, often were included irrespective of their earnings. Here again it was found necessary gradually to extend the income limit so as to make the protection of the law accessible to people with moderate means. Finally the principle was not only applied to industry but increasingly also to commerce, agriculture, and domestic service, with a definite trend toward equality of service for all groups covered.



In 1939, the British law required insurance from all workers, and from those white collar workers who earned less than 250 pounds per year. Similar are the provisions of the Australian scheme. The French law is applied to all employed workers subject to income limits.

Voluntary Subscription—to compulsory programs often was made available to certain groups which, although in need of provisions, could not be required to join the plan because of administrative or other difficulties. They were self-employed people with an average income similar to that set for employed persons; people who discontinued employment covered under the Insurance Law; and people whose income, while fluctuating, exceeded the limit drawn for compulsory insurance.

In their early phases many programs served "wage-earners" only. If family dependents were included they were usually provided with maternity services first. The complete or partial exclusion of family dependents from medical service was soon found to constitute a serious deficiency. Obviously, the efficiency of any compulsory sickness insurance scheme must be considerably impaired if rights and services are unequal for members of the same family. In fact, such a policy must result in adverse consequences by turning family dependents to charity or public assistance and disrupting effective treatment of many diseases. One of the most significant developments in social philosophy is the increasing emphasis laid on the "family approach." There are instances where the family dependents of insured people are eligible for the same type and amount of services as the wage-earners. In other instances provisions for family dependents comprise at least a selected number of fundamental medical services. In those countries where family dependents were covered along with the wage-earners a definite trend developed toward making such service more and more complete. The omission of family dependents from coverage has greatly reduced the value of the British system and those designed along the British precedent.

*Scope and Extent of Medical Care Provisions*—vary widely in various countries. The success or failure of compulsory sickness insurance depends largely on type, scope, amount and accessibility of services established by law. Obviously the insured people must get their money's worth—else required programs cannot be justified. The ideal program calls for every type of service which is deemed to be necessary for prevention, cure and mitigation of illness. On the other hand financial requirements may imply careful selection of such services as are of primary importance to the individual and to the community.

In a number of foreign countries the following services are made available to a varying degree: physicians' care at home, office and hospital, including services by general practitioners and certain specialists; maternity services, including prenatal, obstetrical and post-natal care; hospitalization, including care at general and special hospitals, and at convalescent homes; supply of drugs sub-

ject to certain restrictions; supply of certain appliances contingent upon special requirements. In addition, dental services often are partially or completely included.

There are instances of rather all-inclusive services and most of the schemes provide for hospital care. However, it must be emphasized that in certain countries the type, scope and amount of medical care, provided under compulsory sickness insurance, fall short of modern standards. In fact, the British government did not follow the inauguration of its health insurance program with adjustments from time to time to the progress in scientific medicine. Today, just as in 1911, the "standard medical services" are restricted to such "as can properly be undertaken by general practitioners of ordinary competence and skill," and hospitalization must be purchased by supplementary voluntary plans or, if that is impossible, obtained through public assistance. It is significant that the British Medical Association, representing the private practitioners, repeatedly and strongly advocated the removal of existing defects by extension and improvement of the present scheme rather than by its abolition. A report of the British Medical Association, in 1938, reiterated recommendations made before (Proposals for a General Medical Service for the Nation), and urged broad "extension and amplification" of the scheme. A series of "basic principles" was made public, among them a recommendation "that consultants and specialists, laboratory services, and all necessary auxiliary services, together with institutional provision, when required, should be available for the individual patient, normally through the agency of the family doctor."

*Distribution of Medical Care.*—The private practice of medicine as contrasted to a salaried civil service system has been maintained as a rule. Physicians, engaged in private practice, are free to attend private patients only. They are also free to offer their services for both patients who pay directly and patients for whom the administration of the insurance plans foots the bill. In fact, in most of the countries private physicians render service simultaneously to both groups. Contrary to the general impression, no country abolished private practice. Accordingly the principle of free choice of physicians has been preserved. A person eligible for insurance service was allowed to choose his physician from among all those duly admitted to this type of practice. After ample experience had been gathered as to why people choose and changed doctors a definite trend developed in some countries to substitute directed intelligent choice for undirected free choice.

Free choice was granted as much as possible within reasonable geographic and economic limits. This principle was not applied to individual practice alone. Freedom to offer and seek medical care was interpreted to imply no discrimination against distribution of medical care by medical centers, clinics or "dispensaries" run by groups of physicians, voluntary organizations or public agencies. Certain difficulties developed, due to strict adherence to these basic principles—private practice of medicine and free choice

of physicians. In some countries the ratio of physicians to eligible persons decreased. The caseload of a minority of physicians became too heavy to guarantee careful service. On the other hand physicians who were less willing to yield to every demand of their patients were found to attend a relatively small number of insured patients. This experience resulted in two important steps: First, a limit was set as to the number of people to be served by one physician. Second, professional supervision of professional service was introduced. The purpose of these steps was to protect the great majority of conscientious and careful physicians against the small minority of colleagues who—unintentionally or deliberately—damaged the common interest; to secure competent and good medical care in doubtful cases; and to help maintain a balance between demand of patients and available medical resources.

*Remuneration of Physicians and Allied Groups.*—Physicians and the allied professions are compensated for service rendered under compulsory sickness insurance under three plans: (1) under the “per capita system” the physician is paid a flat rate per year per person on his list; (2) under the case system fixed fees are paid per case of illness attended; (3) under the unit system each service given is paid for on the basis of a special fee schedule. There are also many combinations and variations of these three basic procedures in use.

Examples of each system are: Great Britain for “per capita system;” German republic for “case system;” France for “unit system.”

The method of physician reimbursement is of utmost importance. Careful judgment is necessary in selecting a procedure which does justice to both physicians and patients. The experience gained in foreign countries reveals certain points of general significance. Remuneration on the basis of a standardized flat rate per eligible person, when proposed, usually was opposed by the organizations of the medical profession. To quote an English statement made in 1911: “. . . There is no reason why medical service and aid should be remunerated on a basis different from that of nurses, landlords, or tradesmen.” Similarly a French statement in 1930 pointed out: “. . . nous voulions garder à la médecine son caractère d’élite: 1. par le paiement direct du médecin par le malade, paiement effectué en espèces (sans ticket) et selon les tarifs en usage . . .”<sup>25</sup> “Organized medicine” in every country has always wanted fee-for-service payment. Inevitably the adoption of the fee-for-service system led to the establishment of control methods designed to clear up marked differences in individual bills and to balance between available money and charges of physicians.

A number of small groups of English counties originally adopted the method of payment by fee for each unit of service rendered. After 1914 this system was not retained in any of the areas except

<sup>25</sup> “We wish to keep for medicine its ‘high character.’ 1. by direct payment to the doctor by the patient, payment made in money (without a ticket) and according to customary fees.”



Manchester and the neighboring district of Salford. The Salford and Manchester doctors abandoned the method at the end of 1926 and 1927 respectively, after 15 and 16 years experience with it.

The experience in Manchester<sup>26</sup> showed:

"(1) The number of total items of service mounted steadily from 1,488,292 to 2,374,352 in 1927. The general medical opinion has it that this was caused by a small minority of unscrupulous physicians.

"(2) With a fixed sum available to divide and a constantly increasing number of units of service to be paid for, the payment per item of service became steadily less with each successive year. In 1922 the average cash value per unit credited was \$.52 and it had dropped to \$.32 in 1927.

"(3) The increasing number of annual credits disallowed by the Panel Committee which has risen from 85,974 during 1922 to 205,901 for the year 1927 led to considerable dissent over accounts.

"The general sentiment relative to the change to capitation seems to be a profound relief that bickering over accounts is ended and that bookkeeping is transferred to the Insurance Committee, which pays the doctor according to a uniform system that plays no favorites<sup>27</sup>."

The French system of health insurance is particularly interesting because it is in marked contrast to most others. It was what the profession wanted. But when the physicians had it they became increasingly dubious that it was the system they really wanted. The French physician bills his patient as he chooses and collects what he can. The patient pays his own bill and is reimbursed by his insurance organization up to a certain percentage of the agreed standard rates for specified services.

"In some localities there seems to be strong evidence that the doctors increased their charges after the new law went into effect because of the greater capacity of their patients to pay."<sup>28</sup> This led to dissatisfaction on the part of the insured persons. The greater difference between the fees charged by physicians and the reimbursement payable under the medical benefits brought about a considerable nullification of the insurance itself.

"In France the maintenance of the fee-for-service system with all its implications has led to the introduction of a number of control measures. For example, in Paris 'about 50 percent of the cases are investigated and as part of these investigations about 60 percent of the patients are examined by the physician of the case to check on the record.'

<sup>26</sup> Armstrong, Barbara H., *The Health Insurance Doctor*, p. 44.

<sup>27</sup> In the report of the Royal Commission on National Health Insurance, 1924, Appendix C, p. 9, it was mentioned that some of the Insurance Committees wished to put the Manchester system in effect but the opposition of the medical profession was so great that capitation was retained.

<sup>28</sup> Douglas, Paul H., "The French Social Insurance Act. Philadelphia, Annals of the American Academy of Political and Social Science, 1932.

"Medical supervision, investigation, hearings, etc., bureaucracy, conflicts of opinion on medical issues, conflicts of judgment on costs—these and other difficulties have not been avoided by the French system of remunerating the doctor. On the contrary, by the victory of dictating the system of remuneration and assuring the patient complete free choice of doctor, the French doctors achieved strongest limitation of fees, a complex and cumbersome fee schedule, necessity for close administrative supervision, conflicts with insurance authorities, and a considerable loss in public esteem."<sup>29</sup>

Because of all these difficulties a certain tendency has developed to remunerate physicians on the basis of a flat rate per eligible persons or per clinic session.

The per capita system of reimbursement for the "insurance doctor" in England appears to have decreased the confusion regarding extent of payment for work done and the necessity of extensive checking. Generally speaking under systems of paying flat rates much control, red tape and administrative expenses can be saved.

*Quality of Medical Care*—is improved by excluding quacks and cult practitioners from admission to insurance practice; sorting "insurance practitioners" according to experience and personal qualities; including services by consultants and specialists; supervising physicians and members of allied professions engaged in insurance practice, as to efficiency of their performance; providing for all necessary diagnostic and therapeutic procedures; emphasizing early and frequent hospitalization at hospitals of high standards.

Quality of medical care cannot be measured and appraised in terms of statistical data. Factors of decisive importance to the maintenance of high standards in medical care are first, caliber of physicians, dentists, pharmacists, nurses and all other related groups; second, type, amount and accessibility of services offered; and third, the extent to which these services are used. An inadequate volume of services cannot be satisfactorily balanced by the availability of a sufficient number of well-trained personnel. Provision for a sufficient quantity of service can not offset the lack of well-trained professional people. As conditions vary so widely in the various countries no brief summary of the relevant facts can be made here. A more detailed study would have to take into account all the points mentioned before.

*Scope and Extent of Compensation for Disability*.—A fundamental change has taken place in the concept of the purpose and functions of compulsory sickness insurance. Fifty years ago there was some justification in believing that "the dominant motive in the establishment of every system of health insurance is the relief of poverty, not the preservation of public health." Ample experience during the past half century bolsters the conviction that the functions of compulsory sickness insurance are much wider and quite different in scope. Thirty years ago two significant statements were made indicating this change of concept. The Preamble to the

<sup>29</sup> Falk, I. S., *Security Against Sickness*, 1936, pp. 235-236.

British National Health Insurance Act of 1911 defined the act as "an Act to provide for insurance against loss of health and the prevention and cure of sickness and for purposes incidental thereto." The 1911 proposal for a Federal Insurance Code in Germany, pointed out: "the granting of cash benefits . . . is undoubtedly one of the less valuable forms of insurance benefits . . ." In both instances compensation for disability was not regarded as being outside the scope of health insurance—which was the philosophy elsewhere. Because of the interdependence of illness and economic condition, provisions for medical care and compensation for loss of earnings due to disability, were usually combined.

Long experience has shown that no insurance program against the risks of ill-health can properly function without disability compensation. Experience also led to the conviction that a liberal provision for medical care was the best way to prevent dependency and reduce the need for extensive compensation for loss of earnings. There are wide variations in the rates of cash benefits to compensate the insured person for wages lost due to disabling illness, injury or maternity. In most of the countries at least half of the wages is taken as the basis of cash benefits, and in some countries two-thirds.

In a considerable number of foreign countries certain trends have developed. First, medical care was ranked ahead of cash benefits. In many countries the expenditure for medical care rose proportionately more than that for cash benefits. In 1933 the ratio of expenses for medical care to expenses for cash benefits was approximately 4:1 in Denmark, 3:1 in Poland, 3:2 in Germany and 7:10 in Great Britain. In 1935 the respective ratio in France was 5:2 for non-agricultural workers and 3:1 for agricultural workers, maternity payment excluded.

Second, compensation increasingly was paid in a certain proportion to the wages earned rather than as a flat rate, so as to help the insured people in maintaining their usual standard of living.

Third, a steady tendency developed towards the application of a sliding scale of compensation so as to give reasonable support to large families and people in the lowest income groups rather than to single individuals and insured people with higher income.

*Administration*—of the foreign sickness insurance schemes usually has been placed under the authority of autonomous self-governing bodies. The sickness insurance system was separated both financially and administratively from existing public health or welfare agencies. The democratic principle and concept of self-government, while chosen for governing the pattern of organization and administration, presented difficulties in practice. So far, no magic formula has been found to solve all the problems in a way which suited everyone.

The principle of self-government was applied to all concerned rather than to only a few groups. In the first phase of development, insurance schemes in many countries were administered by laymen only. It is a poor policy to refuse those who render the



services, primarily the physicians and allied professions, an equal opportunity for administrative responsibility. This omission has become a source of persistent unrest and strain under certain foreign plans. It has led to the deep-rooted conviction that compulsory sickness insurance inevitably had the implication of lay control over professional services. In the second phase of development—rather late—the medical and related professions were authorized to take an active part in the administration. Local administration of medical service either was divorced from management of cash payments (Great Britain) or the program as a whole was managed by a self-governing body composed of representatives of the insured people, employers, medical and allied professions, and public health agencies. Central administration was placed either in Departments of Labor (most of the countries) or in Departments of Health (Great Britain, excluding Northern Ireland); often—but not always—medical officers were in charge of a division of these departments.

Another clash of group interests with community interests occurred when it came to the formation of efficient administrative bodies. In designing the plan of administration, governments in nearly all countries were confronted with vested interests created by the numerous associations and corporations operating voluntary sickness insurance programs. To quote from an English source "there had grown up a number of 'clubs,' medical aid societies, friendly societies and trade unions which provided their members with contract medical services. These voluntary organizations often had to be approved as legal organs ('approved societies' in England) although many were financially weak, covered only a small number of people and served only a certain economic or occupational group."

Administrative efficiency of compulsory health insurance depends largely on the size of the units. In a slow and long process two lessons were learned: First, concentration of administration is superior to decentralization in numerous small units. Second, the district basis is preferable to the local basis because: the risks can be spread better and medical services organized more easily; discrepancies between the performance of the units can be reduced; management can be simplified; overhead kept down; and, coordination with existing health and welfare agencies made easier. In fact, there has been a definite trend towards creation of large administrative units, locally subdivided, and the elimination of small units.

*Financing and Costs.*—In financing compulsory sickness insurance the contributory principle has been predominant and tax-support has remained a minor feature. The programs have been financed primarily by regular contributions both from the people covered by the programs and the employers of insured people.

The proportionate share of contributions made by employers and employees has been established in different ways. In broad terms there are countries, such as Great Britain and France, where the employers match the contributions of their employees on a 50:50

basis. In other countries the major responsibility was placed on the insured themselves, who often paid two-thirds of the total contributions. This, of course, gives only a rough picture of the situation. Experience has demonstrated the necessity of special regulations which deserve careful consideration. In industries where there is an enhanced danger from occupational diseases, the employer's share should exceed that of the wage-earner, and people in the lowest income group should be privileged by the payment of only nominal contributions. In determining these rates either the flat rate or the sliding scale of rates has been employed. In a number of countries establishment of rates in proportion to wages has been given preference, but then the calculation has been based on "wage groups" rather than on individual wages so as to simplify administration. The size of the total contributions usually has been left flexible within definite limits. The law allowed the local administration to adjust the size of contributions to the local needs and resources yet forbade an increase beyond a fixed percentage of the pay-roll.

Many countries have provided for government subsidies derived from tax revenues to supplement the contributions of employer and employee. Such appropriations were either earmarked for administrative purposes or special services, or they were made without definite stipulations. Since 1926, the English government has borne one-seventh of the total health insurance budget in the case of male and one-fifth in the case of female members. In the neighborhood of 15 percent of the total income of the health insurance scheme came from these grants-in-aid. In other instances the government subsidy amounted to more than this (Denmark) or only to a small fraction of the budget of compulsory sickness insurance. Due to the wide variations in coverage and functions of the various schemes no general comment can be made regarding the part of the payroll required to pay the contributions of both employers and employees. There is, however, evidence that a total of 5-6 percent of the payroll has been sufficient to defray the costs of rather inclusive provisions for medical care and reasonable disability compensation.

The utmost care must be taken in drawing conclusions from foreign cost figures. Any comparison of rates or proportions is fallacious because of the tremendous variations and steady changes in service, method of physicians' remuneration and population groups covered. In addition it is hardly possible to express foreign figures in terms of dollars because of the differences in purchasing value and the fluctuations in exchange. Any attempt to use financial data from foreign experience for plans to be designed in this country would result in confusion rather than enlightenment. If compulsory plans are to be considered in this country the detailed cost figures must be estimated. Of prime importance would be type, scope and amount of services and benefits to be included; methods of distributing medical care; method of physicians' compensation; type and income of groups to be covered; health status

in the various communities and probable demand—to mention only a few basic factors.

### Lessons from Foreign Experience—Strong and Weak Points

The significance of foreign movements towards compulsory sickness insurance is revealed in the following principal trends:

1. There has been a steady trend towards replacing voluntary by compulsory programs—first, in Europe, later, in many other parts of the world.

2. The inalienable right to seek and expect a certain amount of security against illness has been firmly established for substantial groups, often the majority of the various peoples.

3. In adopting sickness insurance programs the governments in a steadily increasing number of countries turned from legislation for abatement of nuisances and prevention of certain communicable diseases to legislation concerned with social security. To the negative approach of forbidding, government added the positive approach of granting something, and substituted comprehensive planning for isolated procedures.

4. The various governments issued detailed laws which clearly defined the rights and the duties of the people; supervised the operation of the programs which were managed by self-governing bodies; and assisted the programs by sharing a part of the costs.

5. Because of the interdependence of illness and economic conditions the programs as a rule were inclusive in the sense that they provided for both medical care and compensation of wage loss.

6. Restoration and improvement of health, originally a by-product of the plans, has become a major objective. There has been developed a definite trend to rank compensation for disability second to provision for medical care.

7. Compulsory sickness insurance, originally designed for specific groups of wage-earners, has been expanded to include larger economic occupational sections of the populace, to cover family dependents along with the wage-earners, and also to serve people who joined voluntarily.

8. Scope and amount of medical care has been steadily increased in line with stronger emphasis laid on service rather than on payment of cash.

9. Distribution of medical care has been usually based on the precept of the private practice of medicine.

10. Quality of medical care has been increasingly emphasized, primarily by excluding from participation quacks and cult practitioners, and by improving the type and extent of services available.

11. Compensation for disability has remained an important feature of the programs although it has advanced proportionately on a smaller scale.



12. Administration of compulsory sickness insurance has been severed from some of its worst original features by the development of professional supervision of professional services and by the attempts to create efficient large-size administrative units.

13. The costs of the programs have been met primarily by contributions from both the insured and employers and on a small, although varying, scale by government subsidies.

14. In no country was compulsory sickness insurance designed to solve the problem of medical care for all groups of the population. Being a device for self-help by self-supporting people and a technique of dealing with the economic risks of illness it did not, and could not, make other methods superfluous. Voluntary insurance and tax-support still were employed for those for whom the contributory and compulsory principle was not feasible.

Experience has also shown that no human being has been able to present a formula which suits all. For nearly 60 years the best brains in many countries have tried to reconcile justified demands for medical care with an economical and efficient method of providing it. No complete solution was ever found. Patients are human beings, so are doctors.

What gives strength to the policies and procedures adopted in foreign countries is first, the approach, namely the subordination of group interests to those of all; second, the clear recognition of social obligations in the field of medical care; third, the constant drive to reduce admitted incompleteness of the compulsory health insurance plans.

It is only natural that a proposal such as compulsory insurance stirs up clouds of prejudices and misconceptions. It would be foolish to deny that there have been, and still are, many weak points and deficiencies in foreign sickness insurance schemes. However, this country, if and when it wishes to adopt similar laws, can start from the vantage point of the vast experience accumulated in a 60 year period of trial and error.

The basic problem which must be faced by every medical practitioner is ably stated<sup>30</sup> by the President of the French Medical Association:

"It merits emphasis that health insurance, by throwing a constant spotlight on the extent of illness, its neglect, and its enormous cost, is promoting the cause of preventive medicine in all fields. That this cause must become the concern of the individual practitioner, if the traditional doctor-patient relationship is to survive, is a growing conviction of the leaders in organized medical circles in France, as in Britain and Denmark. This conviction is well expressed in an editorial in the *Rhône Medical Journal* penned

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<sup>30</sup> See Armstrong, Barbara, "The Health Insurance Doctor," 1939, pp. 257-258.

by the 1936 president of the French Medical Association (14) under the title 'At the Crossroads':

'Events are taking place at a rate that could not have been foreseen. Those that flattered themselves that they would direct them find themselves obliged to follow them instead.

'At this point it behooves all of us who would preserve the free practice of medicine to take a clear view of the situation.

'The time is over for academic discussions.

'Will we cling tenaciously and hopelessly to the classic conception of the practice of our profession, or will we have the wisdom to realize that hitherto we have visualized a far too limited function for our profession? If we select the first alternative, then, I will state bluntly, it is the end of our profession. So much the pity for those who close their eyes to this fact . . . They will have been the principal builders of their unhappy fate.

'If we select the second alternative, if we realize that our function is not confined to the individual treatment of a sick person, if we can see that we must concern ourselves with social planning, there will yet be happy days for the profession of medicine and physicians will enjoy the gratitude and esteem of those who devote themselves to general hygienics and to the future condition of the French people. We can and must become both the counsellors and technical agents of the public authorities in the great organizations which devote themselves to improving the public health. Let us learn to collaborate. Let us learn to rid ourselves from our far too narrow conception of the proper role of the medical profession. 'Healers of the sick' is, of course, a glorious title, which still should command respect.

'But let us not keep in sight merely the maintenance of our traditional Charter of Medicine.

'The Charter's terms will be better accepted the more we set ourselves everywhere throughout the country to developing and evolving and to aiding with our technical skill the cause of general prevention and early diagnosis of disease.'''

It would be indefensible indeed if any State in this country imported and repeated the mistakes made abroad. Foreign experience can clearly demonstrate stumbling blocks and shortcomings which must and can be avoided. From the oldest law, the German, we can learn how detrimental it is if the medical profession is kept out from active participation in administering sickness insurance. The recently established French law shows the disadvantages of the indemnity and fee-for-service idea. The British experience illustrates that a plan with no provision for certain specialists' services, hospitalization, and services to family dependents arouses more and more criticism from the physicians themselves as well as the insured persons. In addition, it reveals the deficiencies inherent in the existence of a great number and variety of administrative units. Finally, all these programs illustrate what happens if schemes based on the insurance principle are not from the outset

coordinated and integrated with all other community health and welfare programs, both voluntary and public.

### Workmen's Compensation in the United States

Workmen's compensation is a method of applying the idea of compulsory insurance against two specific risks to health, namely industrial accidents and occupational diseases. Hence, it is compulsory health insurance in essence although not explicitly in form. The development of workmen's compensation in this country gives insight into many problems of primary importance to compulsory sickness insurance.

Between 1886 and 1917<sup>31</sup> nearly every important industrial state in this country modified or abrogated one or more of the common law defenses, which protected the employer against actions for damages growing out of accidents to his employees, and introduced the system of "Legal liability of the employer." This led to employers being involved in a mass of litigation and they found insurance companies ready to assume the risk and profit. Thus, in 1886, appeared the Employers' Liability Carrier. The insurance companies took the place of the old common law defenses as the insuperable obstacle to any adequate recompense to the injured workers or their families. How effective they were in fulfilling this objection is shown by J. R. Commons' description<sup>32</sup> of what took place in Wisconsin:

"Employers in Wisconsin paid \$1,225,000 to liability insurance companies in 1911; scarcely \$300,000 of it reached the pockets of the employees or their dependents. Ten thousand industrial accidents occur in Wisconsin every year; 100 of these are fatal; the others cause disability of seven days or more. Scarcely 10 percent of the injured received any share of the \$300,000."

The Minnesota Bureau of Labor, Industries and Commerce<sup>33</sup> after an investigation throughout the country, reported:

"In 1905 the Casualty Companies doing business in New York State received in premiums from employers \$4,381,634 insuring them against liability towards employees for accidents. Now of this sum 28 percent went to pay the expenses of the insurance companies in defending suits or in profits and only 32 percent went to workingmen as a compensation for injuries received in cases which come up against companies. . . ."

"In the ten years ending with 1907, \$82,732,705 were collected as premiums by eight of the largest liability companies in the United States and \$34,941,103 (or 42 percent of the premiums) were paid out in losses to 1,619,607 injured workmen. . . ."

<sup>31</sup> Medical Relations under the Workmen's Compensation, Revised 1935 Report of the American Medical Association, p. 10.

<sup>32</sup> Commons, J. R., Industrial Commission of Wisconsin, Its Origin and Methods, Survey, Jan. 4, 1913, p. 3.

<sup>33</sup> Bruere, Robt. W., Compensation and Business Ethics, Harpers Magazine, July, 1915, pp. 210-219.



The defects of liability insurance became so flagrant that employers as well as employees demanded that the United States follow the example of Europe by substituting the principle of "occupational risk" for that of "employer's liability."

Subsequent to the Federal Employees Compensation Act of 1909 one state after the other adopted so-called Workmen's Compensation Acts. In 1939, 47 states<sup>34</sup> had such laws in operation. Workmen's compensation still persists in two-thirds of these states on a voluntary basis exclusively. Five of the states have competitive State Funds. Two other states have exclusive State Funds but allow self-insurance under adequate financial safeguard. In eleven states in addition to a State Fund the employer may insure his liability either with private carriers (stock or mutual at his choice) or he may self-insure.

While all the laws actually in operation cover accidental injury, only about half of them include occupational diseases on a varying scale.

A provision for medical care in the early laws was meagre. A few observers in the first stages of workmen's compensation recognized that a wrong start had been made in placing all emphasis on cash compensation to the neglect of medical services.

In an address before the fourth annual meeting of the International Association of Industrial Accident Boards and Commissions in 1919, Edward F. McSweeney<sup>35</sup> said:

"It was recognized by the committees which studied the subject before the enactment of these laws in the various states that the larger part of their administration would be medical and not legal. Yet in actual practice the legal and technical aspects overshadow the medical, to the detriment of all concerned."

In recent years there has been a noticeable change in attitude. The medical benefits of workmen's compensation are taking precedence over the cash benefits.

This change of attitude is exemplified in the following quotation from the report of the Industrial Survey Commission of New York (Legislative Doc. No. 87, 1928, pp. 60-61) of which, it is interesting to note, no physician was a member:

"No question is of more importance in the administration of the compensation law than the question of proper and adequate medical and surgical treatment of injured workmen, and the proper determination by medical examination of their injuries. As time has passed since the enactment of the law, the importance of the medical question has been more and more emphasized and recognized. . . .

"In the minds of many, the provisions requiring the employer to furnish all necessary medical care and treatment are among the most important in the law. It has been well said that the

<sup>34</sup> Progress of State Insurance Funds, Bulletin No. 30, 1939, U. S. Dept. of Labor.

<sup>35</sup> Bulletin No. 248, U. S. Bureau of Labor Statistics, p. 283.

crowning glory of the compensation system is its medical service.  
...

Within recent years this tendency to expend money on restoration of health has possibly proceeded at an even more rapid rate than the liberalization of benefit for financial care. Ethelbert Stewart,<sup>36</sup> Commissioner of the United States Bureau of Labor Statistics, stated in April, 1931, that "Through the workmen's compensation commissions of the United States, we pay the physicians and hospitals \$72,000,000 annually." He<sup>37</sup> comments further on the relative increase of medical and compensation payments:

"When we began the administration of workmen's compensation laws, the relation of doctors' bills to compensation, or to the amount that the injured workman got, was 5 percent. Today it is 35 percent and in temporary cases it ranges from 50 to 75 percent of the amount that the injured workman gets."

In New York State for the year 1931<sup>38</sup> medical benefits computed as a third of the total amounted to \$17,621,851 and cash compensation amounted to \$35,243,703. This figure does not include the disbursements of self-insurers.

The State of New York has an Insurance Fund<sup>39</sup> which began operation on July 1, 1914, and is a competitive carrier. During 1938 in New York State approximately 3 million employees were covered and more than 40 thousand employers paid premiums. In 1937 it wrote workmen's compensation premiums totaling \$22,388,366. If written at rating board rates, these premiums would have amounted to \$26,844,564. This was 31 percent of all such premiums written in the State. For a number of years it has written more premiums than any other carrier or compensation insurance in the United States. The fund pays its own administrative expenses, and like all other carriers is assessed to cover the State Labor Department's expenses in administering the Compensation Act. In 1937 the fund's administrative expenses were 16.7 of earned premiums, but figured on the basis of rating board premium rates, this expense ratio was only 13.9 percent. These expenses include funds for extensive safety programs. Premiums are generally 25 percent below the rates charged by private carriers. For special groups of risks, the advance discount is 15 percent and dividends are paid. Some risks, however, whose experience records are consistently poor do not receive a discount until evidence is given that honest effort has been made to reduce accidents. Policyholders cannot be assessed. Compared with non-participating stock casualty company rates, the fund estimates that by the end of

<sup>36</sup> Stewart, Ethelbert: Bulletin 526, U. S. Bureau of Labor Statistics, April 1931, pp. 31 and 74, see p. 97 for actual figures.

<sup>37</sup> Stewart, Ethelbert: loc. cit.

<sup>38</sup> Medical Relations under Workmen's Compensation Report, Revised 1935, American Medical Association, p. 98.

<sup>39</sup> Progress of State Insurance Fund under Workmen's Compensation, U. S. Department of Labor Bulletin No. 30, 1939, pp. 39 and 40.

1938 it had saved its New York policyholders approximately \$49,000,000 in advance discounts and dividends.

Experience with workmen's compensation in this country clearly demonstrates why the pattern used for Workmen's Compensation should be avoided in developing a compulsory health insurance program.

First, many of the unsatisfactory procedures developed under voluntary plans for workmen's compensation were carried over into the compulsory stage and remained to confuse the new administration and to interfere with efficient operation.

Second, commercial exploitation turned out to be one of the worst features.

"Workmen's compensation insurance is written by four types of carriers, radically different in their efficiency to dispense the funds which they collect from employers of labor. The following figures represented in recent years (and perhaps still represent) the fraction of the total premiums retained by the insurance carrier."

"Stock companies .....	38.0-42	percent
Mutual companies .....	20.0	percent
Competitive State Funds.....	10.6	percent
Exclusive State Funds.....	4.0	percent" <sup>40</sup>

Third, adequate provisions for medical care have been generally slow in development, although some states have reached a high standard.

### Summary of Legislative Proposals for Compulsory Health Insurance in the United States

Federal Bills.—On the Federal level two bills must be mentioned.

*The Wagner Bill* (S. 1620) : Introduced in Congress on February 28, 1939, provides under Title XIII Federal grants-in-aid to the states which set up programs for general medical care. No specification is made as to the type of program. The sums authorized under this title are to be "used for making payments to states which have submitted and had approved by the Social Security Board, State plans for extending and improving medical care." Federal grants-in-aid under Title XIII may range from 50 to 16 $\frac{2}{3}$  percent. This has been interpreted to include compulsory health insurance schemes if chosen by the states. Furthermore, Title XIV calls for grants to states for temporary disability compensation.

*The Capper Bill* (S. 658) : Introduced on January 16, 1939, deals specifically with compulsory sickness insurance. It proposes to set up a Federal insurance board for the approval of State systems of compulsory health insurance. All persons engaged in manual labor were to be included in the coverage of such insurance, and all persons employed at other than manual labor and receiving less

<sup>40</sup> Falk, I. S. *Security Against Sickness*, 1936, p. 30.



than \$60 a week. Dependents of employees were to be entitled to medical benefits. Cash benefits to the disabled employee, due after a waiting period of between three and five days, were to be based on 50 percent of the employee's full-time wages with a minimum of \$15 and a maximum of \$25 per week, with additional increases for dependents. Aggregate contributions to the fund were to be 6 percent of the total of all wages paid insured employees. Such contributions were to be paid in shares by the employee, the employer and the state. Voluntary enrollment was included in the provisions of this bill. A director of health insurance as well as an advisory council was provided for at the Federal level in addition to the Federal Health Insurance Board. Allocation of Federal funds to approved state insurance plans were to be subject to the Federal Health Insurance Board's approval. An appropriation of \$200 million per year for distribution to states maintaining adequate systems of health insurance was provided.

*State Bills.*—By 1917 compulsory health insurance bills were introduced and killed in 12 states. Since then many bills have been introduced in a considerable number of states. In recent years four bills have attracted wide attention:

1. *The Epstein Bill:* A model state bill for health insurance, advocated by the American Association for Social Security. The drafting was done principally by Professor Herman A. Gray, of New York University Law School. The bill is in process of revision.

2. *The New York State Wagner Bill:* By Assemblyman Robert F. Wagner, Jr., was first introduced in 1938 and reintroduced in a revised form in 1939. The 1940 version embodied drastic changes.

3. *The California Bill:* Drawn up by the Governor's Committee on Health Insurance, California Assembly No. 1272, as amended April 14, 1939.

4. *The Wisconsin Bill:* Assembly Bill No. 807A, introduced by Arthur Biemiller first in 1937 and again in 1939 with slight revisions.

The elements common to these bills are: application to the whole state; coverage of economic groups within definite income brackets; inclusion of family dependents in scope of service; clause for voluntary membership; right to services including physicians' care by both general practitioners and specialists, hospital care, limited dental care and certain other services; participation in the program open to all physicians; free choice of physician and financing primarily by contributions from both employers and employees and assisted by state government allocations (except Wisconsin Bill). There are also important differences between these bills. The details will be seen from the brief analysis of the various bills in Part IV of this chapter. (See pages 399-406.)

### Problems of Compulsory Health Insurance with Special Reference to New York State

It is well known that the needs and resources of our 48 states vary tremendously. There are differences in size and composition of the population, socio-economic conditions, health status and educational levels. These factors indicate the inadvisability of planning a uniform nation-wide medical care program without taking into account these important differences. While it is natural, rational and economical to prefer overall planning of medical care it is equally imperative to differentiate between individual methods of financing state programs.

Compulsory health insurance has proved to be primarily feasible for industrialized areas with large and stable groups of employees working for salaries or wages, and a densely settled population. The problem in the rural areas is so loaded with difficulties that it would be a waste of effort to consider health insurance for residents of such areas as long as there is no established program in the industrial areas. In a state in which a substantial part of the population consists of independent farmers and persons employed in agriculture, support of compulsory health insurance by contributions would be insufficient, and considerable allocations from taxation would be needed.

On the basis of these facts, if compulsory health insurance is considered, the national approach is preferable. If only some of the industrial states take the lead, while all others refrain from adopting a medical care program of any kind, a rather awkward situation may arise. If an individual state with a substantial industrial population adopts either a compulsory health insurance scheme, or a tax-supported program on a larger scale than before, industry residing in such a state may be put in a less favorable competitive position than industries in other states with less financial obligation. This might lead to the moving of industry from a state with a definite medical care program to a state without any program. Furthermore, a state with a successfully working compulsory health insurance plan may face a break-down of its program when business slumps, wages fall, and unemployment increases. Such a period of economic depression is precisely the time at which industry and labor are least able to contribute to an insurance scheme. There ought to be a reserve fund capable of meeting increased demands in times where there are fewer revenues. If the group covered by compulsory health insurance is small and unable to make the necessary prepayments for rainy days, and if the total population of a state cannot readily raise taxes sufficient to make up the difference, then a system standing alone in an individual state has to bear the brunt of the first shock—and may fall.

*State or Federal System.*—Coordination of state programs, employing various methods, on the Federal level, might help to obviate these problems. The need for the adoption of such a nation-wide policy was emphasized by the Honorable, the Governor

Herbert H. Lehman in his Annual Message to the New York State Legislature on January 3, 1940:

"The State is aiding in the difficult task of distributing medical care to those with modest incomes. But we must also realize that voluntary insurance will not solve the problems of persons with subnormal incomes.

"Our concern for this vast group rests not only upon humane but also on economic grounds. Democracy has a large stake in measures designed to reduce the incidence of illness and disability. Our State, which has accepted the broad responsibility for destitution and dependency, cannot afford to neglect sickness.

"A year ago the people adopted a new article to the Constitution which gives your Honorable Bodies the right to provide a system of health insurance as a protection against the hazards of sickness. As a result we now have a legislative committee studying the entire subject. And I am hopeful that a report will reach you in the near future.

"I am very much in sympathy with the principle of health insurance to take care of the medical and hospital needs of those with subnormal incomes. I am looking forward to the time when such individuals in our State and throughout the Nation will be protected against the hazards of illness by a Federal insurance system. It is my belief that it should become a part of the Federal social security program. As you know, the Congress at this session will give thought to health insurance legislation. To me it seems clear that a satisfactory health insurance system can only be adopted on a National basis."

*Coverage.*—There are many difficult problems involved in the classification of groups to be covered by compulsory health insurance.

There is no divergence of opinion that any medical care program confined to "wage-earner" and excluding his family dependents is contrary to American concepts. Any compulsory health insurance plan in this country should from the very beginning be a family program rather than a plan for the individual.

However, two points must be clarified. First, the family members must be dependent on the insured wage-earner and—as a rule—live in the household of the insured. Second, the term "family dependent" must be qualified. Husbands, wives, and children (including stepchildren and adopted children) of personally insured people should be included if and when they are dependent on the insured and live in his household. Whether grandchildren, parents, brothers and sisters, and grandparents can be granted the same privilege, in the order listed, remains a question of costs and should be left to the discretion of such administrations as are financially able to extend coverage to this extent.

The section of the population to be included in any proposed compulsory scheme may be determined on the basis of income, type of occupation, or kind of establishment in which the respec-



tive persons are employed. Combination of these ways of classification seems to promise the best and most economical solution. I. S. Falk, in outlining the basic principles for an American program points out that coverage "should embrace all medical care and loss of wages on account of sickness bringing variable costs which are burdensome and cannot be budgeted on an individual or family basis."

But how can these economic groups be determined? Where the demarcation line is drawn between those for whom medical costs are burdensome if paid on an individual basis and those for whom there is not a problem, is of far-reaching importance. One school of thought assumes that a family income exceeding \$5,000 a year usually gives security against the economic risks of illness. Families earning less than \$5,000 but more than \$3,000 may have their solvency endangered by the costs of expensive or protracted treatment but may be considered able to meet immediate and urgent medical needs out of their own resources. Families earning less than \$3,000 annually may be regarded as those primarily needing programs which allow them to budget their expenditures for sickness, injury and maternity.

Restriction of compulsory health insurance to low income groups—say up to \$1,500—would endanger the efficiency of the plan and nullify all efforts to remunerate private physicians satisfactorily. The more the risks are spread over a large cross-section of the population, representing various occupational and economic groups, the more can the type, scope and amount of services be increased, operating expenses per eligible person decreased, and rate of contributions kept at a minimum. Legislative proposals in this country vary widely in their choice of coverage.

*Scope of Any Proposed Compulsory Health Insurance Program.*—If we take into account both the evolution and trend of compulsory health insurance abroad and similar proposals to meet medical needs in this country, from the viewpoint of self-supporting people, the medical and allied professions, the hospitals, and the community three basic questions arise:

*First:* Should any prospective program have a wide range and simultaneously provide for medical care to restore health; compensation for wage or income losses caused by disabling illness, injury and maternity; and preventive services for well persons covered?

*Second:* Should any prospective compulsory health insurance program be limited to some of these functions?

*Third:* If such limitation is deemed necessary, what functions should be given preference?

Compulsory health insurance programs with a wide range of functions and a strong emphasis on medical care have been most successful in the past in foreign countries. These expenditures for medical services have outranged and displaced those for disability

compensation. All facts known about needs seem to point to the conclusion that, in any future American program, provision for medical care should have the dominant place, and provisions to meet the economic risks of high-cost illnesses must be particularly emphasized. However, disability insurance must not be barred from the program as a whole. In addition to provisions for medical care, most of the people within the lower income brackets need financial aid when illness lasts more than a few days. The lower the income prior to disability, the greater the responsibility for family dependents, and the longer the duration of disability—the more serious grow the financial difficulties of those dependent on their pay envelopes. There is a definite preventive feature in disability insurance. With compensation for wage loss not only dependency is prevented but people are induced to seek early treatment and to stop working so as to undergo a thorough cure. Without the protection of disability compensation, patients are inclined to postpone medical care and try to go on with their work, particularly in times of mass unemployment, until an advanced stage of illness forces them to discontinue work.

The difficulty lies in finding an appropriate administrative pattern rather than in the principle itself. No objection has been raised to disability insurance as such. In 1938, the American Medical Association, while rejecting "compulsory health insurance," endorsed compensation of loss of wages during sickness "as it has distinct influence towards recovery and tends to reduce permanent disability." It took the following stand with regard to the administrative problem involved: "It is, however, in the interest of good medical care that the attending physician be relieved of the duty of certification of illness and of recovery, which function should be performed by a qualified medical employee of the disbursing agency."

The proof of disability, namely certification of inability to work by reason of illness or injury, has been one of the most troublesome problems for foreign schemes. The only expert competent to certify is the physician. However, many physicians in private practice fear this job involves too many conflicts. There is furthermore the human desire to "get something back," in return for payments made, which may lead to abuse of the provisions for cash benefits. There is no doubt that some abuse from both physicians and patients has existed abroad.

On the basis of this experience two problems are to be solved if and when provisions for disability are introduced in one way or another into a proposed plan: First, should certification be carried out by all private physicians participating in the program, by a selected number of those participating, or by full-time medical officers in the employ of the administration. Second, how can administration of cash benefits be separated from administration of medical care without duplication, red-tape and much overhead.

*Scope and Amount of Medical Care.*—In determining scope and amount of medical care under proposed compulsory health insur-

ance plans the alternatives are an all-inclusive versus a limited program, and unrestricted access to all available medical services versus approval of specified services. The choice depends on the financial implications to the participants namely, employer, employee and the State. Irrespective of any financial considerations one point must be emphasized: A program without provision for such services as are especially costly would miss its main function. In other words, it is services by specialists as well as hospitalization which must be an integral part of a program, in addition to general practitioners' services, clinical laboratory and roentgenological services. "Necessary" drugs and certain medical and surgical appliances should be provided subject to certain restrictions, and dental care, strictly defined as to type and extent, also should be included. Ultimately the problem revolves around the costs of such a program to all concerned. It may be necessary to distinguish between "statutory" services, which are included under all circumstances, because of their fundamental importance, and "additional" services, which can be included, step by step, if the financial condition of the program permits. It is also essential to determine the period for which the various services are granted. Whether any special requirements are to be met before medical care of one kind or another is available under a program must be clarified. There are numerous details which must be worked out carefully. A special consideration of all aspects involved should precede the definite adoption of rules regarding the scope and amount of medical care to be provided.

*Organization of Physicians' Services.*—If under any compulsory health insurance proposal, people are required to budget for their sickness costs then there is a need for assuring that care will be given by competent men. The great variety of professions engaged in the art of healing makes it hard to find a proper and just working definition of competency. The situation is difficult because of the variety of groups concerned. It is intricate because legally acknowledged healing art professions may base their claim for participation in a proposed program on their legal status. This problem should be settled in principle by legislative fiat and not by administrative regulation. Professional services for diagnosis and treatment under a proposed program should be given only by licensed physicians and dentists. Non-physicians should not be permitted independent insurance practice with the exception of optometrists for specified services. All other groups, if licensed, should be admitted to the furnishing of services either on the prescription of a licensed physician, or in cases of emergency. Cultists should be excluded.

The issue is not only distribution of medical care—it is distribution of good medical care by emphasizing the central rôle of the private practitioner of medicine. A series of questions are raised with practical implications. Should participation in the prospective compulsory health insurance plan be open to all licensed physicians willing to accept the terms of a contract between the medi-



cal profession and the administration of the plan? Should participation be restricted to a definite number of physicians selected by their own organization? Should freedom to offer services be interpreted as only referring to physicians conducting individual practice or as also including physicians engaged in group practice? To what extent, if any, should a system of full-time salaried physicians be developed?

If private practice of medicine and free choice of the physician is the basis of the program then no form of practicing medicine can be discriminated against. Much depends on the quality of care given by the participating physicians, both individual and groups, and ultimately the costs of various systems will have to be weighed against accomplishments.

*Remuneration of Physicians.*—Adequate compensation of professional services is paramount. Low pay cannot buy good service. The decision on the method of physicians' remuneration may go in one of three ways or use a combination of two or more of these. Under the fee-for-service system the individual physician is paid for each item of service rendered. Under the per capita system a flat rate per year, or parts of a year, is paid to the physician in accordance with the number of people eligible for his service and regardless of the frequency of visitation. Under the "case system" a fixed fee is paid to the physician on the basis of the number of persons attended, irrespective of the number of services rendered.

These three methods are mostly used in combination and have been tried out in many countries. The salary system has been seldom used to pay insurance practitioners. It has been used primarily for medical officers employed in the administration of the program. Often full-time salaried physicians on the staff of voluntary or public hospitals were responsible for furnishing medical or surgical services during a stay at a hospital, and payment for such services was made by the insurance administration.

Under any proposed health insurance plan the methods for remunerating the physicians—and allied professions should be outlined without specifying the details. The administration of the plan should be authorized to select the appropriate method, scale and procedure of remuneration in close collaboration with the representatives of the medical profession. It may be considered necessary first to try out different methods in different districts. It may be decided to use different methods in the same district. The administration may prefer to refrain completely from any recommendation, leaving it for the medical organization of the respective area to decide the manner of distributing a lump sum, representing a fixed proportion of the total budget, among all participating physicians. There should be statutory provision that the consent of a majority of the physicians, willing to participate, is necessary for the adoption of a certain method and that the administration settles the question if no majority vote is obtained.

Supervision of both services and cash benefits, provided under any system, is necessary because both economy and quality are

necessary. The physician in private practice is sometimes restricted to minimum services for an individual patient who often cannot afford treatments or expensive procedures which seem indicated under modern scientific medicine. Under programs, sponsored by voluntary organizations or public agencies, both the quality of the medical care provided and economy in its distribution are matters of concern to all participants in the program.

The people covered by a medical care program, the participating physicians and hospitals, and the administrative bodies—all want the individual patient to receive the best possible care. As the budget may be limited excessive demands on the part of the patients and a tendency toward wasteful experimentation on the part of the physicians or hospitals must be avoided. This necessity is stronger if patients have completely free choice of physicians and hospitals, and physicians complete freedom of treatment and prescription. Among the patients who are insured some may be inclined to want all possible kinds of treatment irrespective of the costs. The doctor must be protected against unnecessary demands. Furthermore doctors who are not familiar with the special requirements of insurance practice under any proposed program need expert advice and aid as to how to render services of satisfactory quality at reasonable costs. Finally, the honest and careful doctor should be defended against colleagues who by over-treatment, over-medication, over-certification damage the interest of all physicians engaged in such a program.

The balance between medical demands and resources may be attained in several ways. There is first the appeal to the conscientiousness of the physician to furnish satisfactory services with due consideration to economy. There is second, the exchange and distribution of experience gathered in developing satisfactory services at low costs. There is third, the checking of activities of insurance practitioners under any proposed program in order to clear up conspicuous divergencies and to eliminate wasteful operation.

In any proposed compulsory health insurance program consideration should be given to the following principles: First, treatment and prescription must be both adequate and economical; second, standards must be formulated in cooperation between the medical profession and the administration with regard to what constitutes adequate and economical medical treatment and prescription; third, a checking system should be established for securing adequate and economical treatment, adequate and economical prescription, proper certification.

Who should do the supervisory work? It is a deep-rooted opinion that laybodies might take over this task, including the administration of medical care. Lay control of medical care is so much inferior to professional supervision that from the viewpoint of efficiency, not to mention all the other arguments, there is only one answer to the question. The activities of physicians participating in health insurance practice under any proposed program should be super-

vised by medical supervisors. These medical supervisors should not depend for livelihood on either the organized or competitive practice of medicine. They should be full-time salaried officers. Medical supervisors should be licensed physicians, taken from the ranks of the practising doctors, and have at least five years' experience in active practice. They should be appointed with the advice and consent of the local medical organization.

*Estimate of Potential Costs and Income under Various Proposals.*—Many factors of utmost importance yet unknown quantity enter into any consideration of the probable costs of any proposed compulsory health insurance plan.

First the factor of need: The amount of medical care hitherto received by various income groups is no sufficient basis for estimating costs of proposed programs. The volume of medical care received is not ordinarily commensurate with the amount of need regardless of how we may define need. The extent of service given, while showing the quantitative side, does not disclose the quality of care received.

In determining the need for medical care in a given area many elements need to be considered. The main factors involved are:

1. Density, sex and age distribution of the population;
2. Prevailing occupation;
3. Economic conditions in general;
4. Educational level including habits and customs;
5. Type, frequency, and severity of illness, injury, defects;
6. Status of public health and welfare activities;
7. Status of voluntary health and welfare activities;
8. Financial resources of the area with regard to ability to supply institutional facilities and services by professional personnel;
9. Financial resources of the people in various income groups, with regard to ability to purchase medical care;
10. Transportation facilities.

Second, the factor of demand: Need is not identical with the demand for medical care. There may be a definite need, yet little demand because of lack of understanding. There may be a strong demand previously not observed, because people are eager to avail themselves of services hitherto not accessible at favorable terms. Variations in demand—just as variations in need—naturally produce quite different utilization of facilities and a considerable range in costs. Whether increasing demand because of increased availability of professional services necessarily spells abuse is open to wide interpretation. One may well argue that treatment of early cases, minor ailments and borderline conditions is indispensable to any proposed program which has for its objective prevention of complications and chronic stages of illness.

If any proposed compulsory health insurance program is designed to provide good medical care then the demand may increase, at



least during the first years of operation, when many a patient may seek advice, examination or treatment previously deferred.

Third, the factor of the scope of program: It is obvious that a program conducted on a limited scale with respect to professional services involves lower costs than an all-inclusive program operated without any restrictions.

Fourth, the factor of organization: The methods adopted for distributing medical services and organizing disability insurance under any proposed program may have profound effects on the ultimate costs of medical care as well as the extent of cash benefits.

There is a wealth of material available on the costs of medical care under a wide range of programs. This material should be considered against the background of foreign experience. However, without knowledge of the general policy and detailed procedure likely to be adopted in any proposed program, it is extremely difficult to arrive at a fair estimate of probable costs of any such plan. Compulsory health insurance might help selected groups of the population to pay for certain services. It is doubtful that it would not finance even a fraction of the institutional facilities or many of the special services necessary for the population as a whole or for the control of certain groups of diseases.

Data most relevant to any proposed compulsory health insurance plan might be taken from the experience of industrial corporations and voluntary prepayment plans, both group hospital and general plans. The studies conducted by the Committee on the Costs of Medical Care, the United States Public Health Service, the American Medical Association, and the Metropolitan Life Insurance Company—to name only a few—show the potential range of average costs.

According to the Commission on Economic Security and the Interdepartmental Committee to Coordinate Health and Welfare Activities “. . . a comprehensive system of health insurance nationally developed would call for total funds equal to four and a half percent of income of the covered population” and “. . . temporary disability compensation . . . would involve a cost of approximately one percent of wages.” These figures seem to conform roughly with the experience abroad.

The first figure, for health insurance, is based on numerous studies of actual family expenditures for medical care. It was found that in general the average proportion of family expenditures spent for medical care is “surprisingly constant whatever the income or type of community.”

The second figure, for disability compensation, is based on the assumption “that the proposed insurance system is to cover all wage-earners and salaried workers with a seven day waiting period, 26 week benefit period, a qualification provision having the same degree of strictness as the eligibility requirements of the British system and a benefit formula essentially the same as used in unemployment compensation.”

If we apply these estimates to proposals for New York State the cost and potential coverage is revealed in the following:

The income necessary to meet these expenses, on the basis of the Assembly Bill, Introductory Number 2726, introduced in 1939 by Robert F. Wagner, Jr., in the New York State Assembly, would total \$162,760,668. The employee would contribute over 59 million, the employer over 70 million, and the State 32½ million, as shown in the following table.

TABLE 108

## EXPECTED INCOME OF A STATE HEALTH INSURANCE FUND

Based on 1937 Wage Income Distribution Data Prepared by the Federal Social Security Board and Calculated by Applying the Premium Rates Proposed in the 1939 New York State Wagner Health Insurance Bill. (For full text see Appendix O, pages 483-492.)

	Total *	State	Employer	Employee
Total.....	\$162,760,668 05	\$32,552,133 61	\$70,415,351 99	\$59,793,182 45
Under \$1,000.....	51,402,953 90	10,280,590 78	30,841,772 34	10,280,590 78
Under \$100.....	820,022 45	164,004 49	492,013 47	164,004 49
\$100-\$199.....	1,831,638 10	366,327 62	1,098,982 86	366,327 62
200-299.....	2,678,099 25	535,619 85	1,606,859 55	535,619 85
300-399.....	3,615,721 05	723,144 21	2,169,432 63	723,144 21
400-499.....	4,504,039 30	900,807 86	2,702,423 58	900,807 86
500-599.....	5,577,252 55	1,115,450 51	3,346,351 53	1,115,450 51
600-699.....	6,696,842 90	1,339,368 58	4,018,105 74	1,339,368 58
700-799.....	8,183,024 45	1,636,604 89	4,909,814 67	1,636,604 89
800-899.....	8,476,724 50	1,695,344 90	5,086,034 70	1,695,344 90
900-999.....	9,019,589 35	1,803,917 87	5,411,753 61	1,803,917 87
\$1,000-\$1,999.....	86,510,184 10	17,302,036 82	34,604,073 64	34,604,073 64
\$1,000-\$1,499.....	46,904,373 50	9,380,874 70	18,761,749 40	18,761,749 40
1,500-1,999.....	39,605,810 60	7,921,162 12	15,842,324 24	15,842,324 24
\$2,000-\$2,499.....	24,847,530 05	4,969,506 01	4,969,506 01	14,908,518 03

\* According to the 1939 Wagner Bill, manual workers, all wage groups, are covered; non-manual workers with annual incomes of more than \$2,500 per year are not covered. Therefore, the estimates given above are probably somewhat lower than might be actually expected since a great many manual workers in industry have incomes of over \$2,500 a year and have not been included. The Social Security Wage income data available did not present a break-down of manual and non-manual wage income groups and therefore the 8 percent of the wage earners in the income groups of \$2,500 and over were not included.

Under proposed Federal legislation the State would be reimbursed up to 50 percent of its expenditures (Wagner Bill) or 25 percent (Capper Bill) through Federal grants-in-aid.

Most of the proposed plans provide for contributions to the Insurance Fund by both employees and employers and additional allocations from the State. On the basis of the (1939) New York State Wagner Bill the distribution of financing would be as follows: (Schedule was revised in 1940 Wagner Bill)

Weekly income groups	Employee	Employer	State	Total
\$20 and less .....	1%	3%	1%	5%
\$20 and less than \$40.....	2%	2%	1%	5%
\$40 and over .....	3%	1%	1%	5%

The basic question involved is whether both employees and industry are able to contribute their share and whether the increase in the fiscal budget requires special measures.

The development of a proper technique for collecting the contributions is essential. The prompt and accurate payment of contributions can be secured in the best and simplest way if the contributions are collected at the source and under the responsibility of the employer. The technique of raising the money by payroll deduction has proved its value in numerous group payment plans. It can be presupposed that the great majority of the employers will cooperate willingly in the interest of their employees. Provisions against violations of the law, however, are unavoidable although there is every reason to believe that their application would rarely be necessary. The stamp system is preferred by some to a system requiring the transfer of money.

With the development of administrative machinery for operation of the unemployment and old-age insurance provisions of the Social Security Act, valuable data are becoming available upon which to base estimates of the number and income of employees in the various wage classes. The following figures for the year 1937 were prepared by the Bureau of Old Age Insurance of the Social Security Board:

### Employment and Payrolls <sup>41</sup>

Average Earnings of Employees in New York State in 1937.—Approximately 4,000,000 individual workers, an average of 3,094,587 workers in the highest pay period in each month of the year with total earnings of \$3,820,002,000, were reported by employers subject to the New York State Unemployment Insurance Law during 1937. According to these records, the average per capita wage in this group of insured workers for the year was \$955. This omits any consideration of wages earned by these persons outside of employment covered by the law. As compared with these figures, reports of the Bureau of Old Age Insurance of the Social Security Board show a total of 4,055,650 employees with total earnings of \$4,225,043,000 reported to the Federal authorities by New York State employers.

The per capita annual income of \$1,042 for those covered by old-age insurance compares with the \$955 indicated by the State's unemployment insurance records. This discrepancy of nearly \$100 in annual earnings is explained largely by difference in the coverage of the State and Federal laws and by the shifting of employees from insured to uninsured employment.

<sup>41</sup> Placement and Unemployment Insurance Activities, Vol. 1, No. 4, April, 1939, p. 17.



TABLE 109

DISTRIBUTION OF NUMBER OF COVERED WORKERS AND AMOUNT OF EARNINGS IN NEW YORK STATE AND THE UNITED STATES, BY WAGE CLASS, 1937

(Old Age Insurance Provisions of Social Security Act)

WAGE CLASS	EMPLOYEES			WAGES <sup>b</sup>		
	Number	Percent of total	Cumulative percent	Amount	Percent of total	Cumulative percent
New York State						
Total.....	4,055,650	100.0	.....	\$4,225,043,098	100.0	.....
Under \$100.....	393,719	9.7	9.7	16,400,449	0.4	0.4
\$100-\$199.....	248,569	6.1	15.8	36,632,762	0.9	1.3
\$200-\$299.....	215,657	5.3	21.1	53,561,985	1.3	2.6
\$300-\$399.....	207,363	5.1	26.2	72,314,421	1.7	4.3
\$400-\$499.....	200,629	4.9	31.1	90,080,786	2.1	6.4
\$500-\$599.....	203,422	5.0	36.1	111,545,051	2.6	9.0
\$600-\$699.....	206,565	5.1	41.2	133,936,858	3.2	12.2
\$700-\$799.....	218,176	5.4	46.6	163,660,489	3.9	16.1
\$800-\$899.....	199,744	4.9	51.5	169,534,490	4.0	20.1
\$900-\$999.....	190,261	4.7	56.2	180,391,787	4.3	24.4
\$1,000-\$1,499.....	762,405	18.8	75.0	938,087,470	22.2	46.6
\$1,500-\$1,999.....	460,702	11.4	86.4	792,116,212	18.7	65.3
\$2,000-\$2,499.....	224,028	5.5	91.9	496,950,601	11.8	77.1
\$2,500-\$2,999.....	121,834	3.0	94.9	332,261,015	7.9	85.0
\$3,000 and over.....	202,576	5.0	100.0	637,568,702	15.1	100.0
United States						
Total.....	30,157,694	100.0	.....	\$26,825,366,241	100.0	.....
Under \$100.....	4,412,090	14.6	14.6	170,762,319	0.6	0.6
\$100-\$199.....	2,248,961	7.5	22.1	330,018,345	1.2	1.8
\$200-\$299.....	1,801,661	6.0	28.1	446,532,206	1.7	3.5
\$300-\$399.....	1,642,580	5.5	33.6	572,185,442	2.1	5.6
\$400-\$499.....	1,545,237	5.1	38.7	693,815,050	2.6	8.2
\$500-\$599.....	1,521,163	5.1	43.8	834,116,761	3.1	11.3
\$600-\$699.....	1,539,184	5.1	48.9	997,467,708	3.7	15.0
\$700-\$799.....	1,538,485	5.1	54.0	1,152,841,818	4.3	19.3
\$800-\$899.....	1,393,962	4.6	58.6	1,182,686,486	4.4	23.7
\$900-\$999.....	1,335,994	4.4	63.0	1,265,962,141	4.7	28.4
\$1,000-\$1,499.....	5,272,263	17.5	80.5	6,846,142,544	24.2	52.6
\$1,500-\$1,999.....	3,087,185	10.2	90.7	5,306,682,731	19.8	72.4
\$2,000-\$2,499.....	1,334,475	4.4	95.1	2,958,638,213	11.0	83.4
\$2,500-\$2,999.....	604,894	2.0	97.1	1,647,115,903	6.2	89.6
\$3,000 and over.....	879,560	2.9	100.0	2,780,398,574	10.4	100.0

\* Based on Federal Old Age Insurance data corrected to March 1, 1939 — See Social Security Board Bulletin, Vol. 2, No. 3, March, 1939.

<sup>b</sup> Does not include that portion of any salary which exceeded \$3,000.

### Necessity for Coordination of Any Proposals for Compulsory Health Insurance with Existing Voluntary and Public Health and Welfare Activities

The historic development in this country has resulted in a large and diverse system of voluntary and public health and welfare activities. Public responsibility, originally centered on control of environmental sanitation and certain communicable diseases, has recently been increasingly assumed for medical care in the broadest sense. There has been a substantial increase in the use of taxation

for the purpose of supporting public medical care and a rapid growth in the use of voluntary insurance particularly in the field of hospital care. In fact compulsory health insurance if adopted would not come in a vacuum.

It is imperative to utilize to the fullest extent existing facilities and services when adequate, and equally imperative to establish close relations between privately supported, tax-supported and insurance programs, both preventive and curative. The precise definition of functions to be fulfilled by any proposed health insurance plan is of paramount importance. Without exact demarcation of functions and scope it would be impossible to determine the proper place and potentialities of the various programs already in existence, and the genuine role of the proposed compulsory or voluntary health insurance plan.

There is a natural partnership between voluntary and public activities in the fields of health and welfare. Yet a bewildering variety of agencies, voluntary and public, are now conflicting with each other with respect to eligibility requirements, services, organization and administration.

If compulsory health insurance is to be superimposed upon an uncoordinated system of existing health and welfare activities, then indeed, overlapping of functions, duplication of services and friction in administration would be perpetuated and extended. This dilemma is not inherent in any proposal for compulsory health insurance and can be avoided. Proposed legislation in this field should be premised upon the coordination of all community health programs.

On the face of it, the remedy seems simple. Unification of all agencies and allocation of all activities along definite lines, would serve expediency and economy better than isolation of agencies, each operating its own complete program without regard to activities conducted by others in the same field. In practice, even such a reasonable objective is difficult to achieve. Long established experience has demonstrated over and over again that proposals for cooperation between existing agencies and coordination are degraded to the status of mere slogans, unless there is over-all planning. This truth is no less valid because it is old.

The British experience should be a warning. In testifying before the British Royal Commission on Health Insurance the Society of the Medical Officers of Health pointed out that their service, "primarily concerned in the preservation of health generally, has from the beginning recognized the impossibility of adequately discharging its function in disassociation from measures for the restoration of health to individuals.

"It has become evident that the present system of National Health Insurance suffers great limitations in its possibility for promoting health, and that profound changes are required if the improvement in the health of the people is to continue to be aided and not impeded by it.

“The scheme . . . is, to a great extent, isolated from the other schemes of the State in operation and doing essentially similar work.”

Lack of balance, continuity, and consistency of medical care has been a real problem for many foreign countries. If these developments had been foreseen at the beginning they might have been avoided. Instead, the proper moment for designing a broad program, namely, at the beginning, was missed and only partial compromises could be made.

Thomas Parran, Surgeon General of the United States Public Health Service, has pointed to this problem by saying:

“We cannot continue to think in terms of the separateness of public, private and voluntary efforts or of the separateness of preventive and curative efforts.”

Any legislation, designed to make possible for all persons an equal opportunity for health and medical care of high quality, should require working agreements between all health and welfare agencies to insure success.



## PART IV. ADDENDA.

**Enabling Legislation in Various States Dealing with Voluntary Non-profit Prepayment Plans for Medical Care**

The increasing demand for some method to allow for the budgeting of the costs of medical care has not been confined to the State of New York. Various State medical societies, legislators and organized groups have been active in promoting such plans.

As a result of such promotion, enabling acts for medical care corporations on a non-profit basis was passed during the 1939 legislative session in the states of Michigan, Connecticut, Pennsylvania and New York.

Similar bills were introduced in at least 11 other states. A listing of such states included Arkansas, California, Illinois, Missouri, Ohio, Utah, Washington and Wisconsin.

The following is a brief review of the important sections of the bills passed in several of the states, in order to compare certain administrative and supervisory characteristics with those included in Article IX-C of the New York State Insurance Law.

*Pennsylvania.*—In the 1939 Pennsylvania Legislature, there were passed General Assembly Acts No. 398 and No. 399, specifically designed for the purpose of bringing a more satisfactory distribution of medical care to persons of low income. Section 2 of General Assembly Act No. 399 states the necessity of adequate medical care for the residents of the state as follows:

“Section 2. Declaration of Necessity.—It is hereby declared that adequate medical services are essential for the maintenance of the physical and mental health of the residents of the Commonwealth, and that it is necessary that provision be made for adequate medical services to persons of low income who are unable to provide such services for themselves or their dependents without depriving themselves or their dependents of such necessities of life as food, clothing and shelter, while maintaining the standing and promoting the progress of the science and art of medicine in this State.”

Section 9 of the same act makes mandatory that the activities of the non-profit medical service corporations shall be confined to the low income groups, and places with such medical service corporation the responsibility of judging what individuals are eligible to become subscribers:

“Section 9. Determination of Income Status; Rights of Persons of Low Income.—(a) The following shall be a person or persons of low income eligible for the benefits of and under this act:

“(1) In the case of persons without dependents: Any person in receipt of an income, for the preceding twenty-five weeks, averaging not more than thirty dollars weekly.

“(2) In the case of persons with one dependent: Any person in receipt of an income that, together with the income of the dependent,

averaged, during the preceding twenty-five weeks, not more than forty-five dollars weekly.

“(3) In the case of persons with more than one dependent: Any person in receipt of an income that, together with the incomes of all his income earning dependents, averaged, during the preceding twenty-five weeks, not more than sixty dollars weekly . . .

“Section 9. (b) The non-profit medical service corporation shall determine whether an applicant for subscription is in receipt of a low income within the meaning of this act and after the application has been approved, the subscriber shall be deemed to be of low income until it has been redetermined by the corporation which redetermination may be made at any time.

“(c) The non-profit medical service corporation, in determining the income status of any person, may, through its officers and agents, examine under oath any applicant claiming a low income status and any other person consenting thereto who is believed to have material knowledge concerning the status of the applicant. Its determination shall be final.”

Section 11 of the same act provides that relief officers may enroll as subscribers to such plans those individuals who are unable to provide medical care for themselves and for whom the provision of medical care is a responsibility of the relief officer.

“Section 11. Relief Officers May Subscribe for Service.—Every department, commission, officer and other agency of the State, or of any political subdivision thereof, who is charged by law with the duty of providing medical services, with the meaning of this act, for persons unable to provide it at their own expense or to procure it through persons to whose support and assistance they are by law entitled, is hereby empowered, in the exercise of his authority, to provide such service if, in his judgment, it is in the public interest so to do, through a subscription or subscriptions, paid for from any lawfully available public funds, with any non-profit medical service corporation on behalf of any person or persons entitled to such relief.”

The Pennsylvania bill is also unique—in that it makes provision for state supervision of the quality of medical care which is to be rendered by the medical service corporations operating under this new legislation. This responsibility is placed with the Department of Health. Section 15 of Act No. 399 gives the Department of Health very broad powers to inquire into the medical activities of such corporations, and to determine whether or not adequate medical services are being provided for subscribers in accordance with the best medical practice in the community. In the event the Secretary of Health shall find that this is not being done, he may notify the corporation of his findings and order the corporation in specific terms to extend or improve the medical services rendered by the corporation. It is further provided that such corporation shall file with the Department of Health a medical service report.

The Departments of Health and Insurance have not only responsibility for approving or disapproving the articles of incorporation, but they are charged with the general supervision of the activities of such medical care corporations. Such corporations under the Pennsylvania law may only provide medical service to subscribers through doctors of medicine.

Section 8-b of Act No. 399 provides for the free choice of a physician by the patient and the medical service corporation shall impose no restrictions as to the methods of diagnosis or treatment, or interfere with the relationship which exists in a community between the physician and the patient.

In order to eliminate the possibility of cash benefits the following language is used:

“Section 9-e.—No contract by or on behalf of any non-profit medical service corporation shall provide for the payment of any cash or other material benefit by that corporation to a subscriber on account of illness or injury, nor be in any way related to the payment of such benefit by any other agency.”

There are the following differences between the New York State and the Pennsylvania state bills enabling the incorporation of non-profit medical plans:

1. The Pennsylvania bill definitely states that only people of limited income may participate. The New York State law mentions no limitation of income.

2. The Pennsylvania law provides for preliminary approval and continued supervision of such plans by the Department of Health to insure the distribution of high quality of medical care. The New York State bill provides for preliminary review of the plan for approval or disapproval by the Department of Social Welfare, but allows for no supervision of the activities of such plans as to the quality of medical care distributed. Such supervision in New York State is theoretically (but not stated) left with the County Medical Society.

3. The Pennsylvania law provides that relief officers can subscribe to such plans for coverage of the totally or medically indigent people under their care, or for whom they are responsible. In New York State, relief officers may subscribe under general authority given them by the Public Welfare Law.

*Michigan.*—The Legislature of Michigan at its 1939 session passed a bill, now Act No. 108 of the Michigan Laws of 1939. The Michigan State Medical Society had promoted the passage of such legislation. The Michigan Act provides for the establishment and maintaining, and operating of a voluntary non-profit medical care plan as follows:

“Section 2.—The purpose of establishing, maintaining and operating a voluntary non-profit medical care plan, whereby medical care is provided at the expense of such a corporation to such persons or groups of persons as shall become subscribers to such plan, under contracts which will entitle each subscriber to definite medical and



surgical care, appliances and supplies, by licensed and registered doctors of medicine in their offices, in hospitals, and in the home . . .”

The Michigan plans are subject to the regulation and supervision of the Commissioner of Insurance. It is provided that he will pass upon all plans, subscriber contracts, prospectuses and proposed advertising to be used in the solicitation of the contracts of subscribers. The Commissioner of Insurance shall have broad powers of examination, including hearing under oath those interested or connected with the proposed corporation.

Section 10 of the Michigan Act codifies the free choice of doctor principle in the private physician-patient relationship as follows:

“Section 10.—Each doctor of medicine, licensed and registered under Act No. 237 of the Public Acts of 1899, as amended, practicing legally in this State shall have the right to register with the corporation for general or special medical care, as the case may be. A non-profit medical care corporation shall impose no restrictions on the doctors of medicine who treat its subscribers as to methods of diagnosis or treatment. The private physician-patient relationship shall be maintained and the subscriber shall at all times have free choice of doctor of medicine. Any employee, agent, officer or member of the board of directors of any such corporation who shall influence or attempt to influence any person in the choosing and selecting of his own physician, shall be guilty of a misdemeanor, and upon conviction thereof shall be punished as provided by the laws of this State.”

Similar to the Pennsylvania law, it is provided that governmental agencies may enroll as subscribers—needy persons under their jurisdiction.

NOTE.—The Michigan law does not state that subscribers to such plans be confined to the low income groups. However, the state-wide plan, which is being established by the Michigan State Medical Society, limits enrollment to individuals with annual incomes not in excess of \$2,500 per year for subscribers with dependents and \$2,000 per year to those individuals having no dependents.

In general, the plan sponsored by the Michigan State Medical Society is quite similar in cost and scope of benefits to those plans at present approved for New York State and previously described. In outlining the proposed Michigan plan, the Journal of the Michigan State Medical Society for 1939 commented as follows:

“The success of the Michigan Medical Service will preclude the entrance of government or lay groups into the practice of medicine, and will insure the objective toward which the Michigan State Medical Society has been striving—the provision of good medical service for all of our people.”

*Vermont.*—Vermont State Legislature Act No. 175, passed in 1939, provides for the establishment of a non-profit medical service corporation to provide on a prepayment basis medical and dental

services. The approval and supervision of such corporations is assigned to the Commissioner of Banking and Insurance. This law provides for the free choice of physician.

It is interesting that the Vermont law allows for the formation of such groups by dentists, osteopaths, chiropractors and chiropodists as follows:

“Section 12.—Three or more persons duly licensed under the laws of this State to practice dentistry, osteopathy, chiropractic or chiropody may incorporate for the purpose of establishing a dental, osteopathic, chiropractic, or chiropodial service corporation, respectively, to furnish dental, osteopathic, chiropractic or chiropodial services, respectively, in the manner and subject to the restrictions specified in this Act with respect to such corporation consistent with the provisions of this Act with reference to a medical service corporation organized hereunder.”

A comparison of the Vermont law with the New York State law reveals that:

The New York State Law makes no provision for the incorporation of groups of dentists, osteopaths, chiropodists and chiropractors. In the New York State law it is assumed that osteopaths are included, since they are classified as duly licensed physicians.

*Connecticut.*—The Connecticut Legislature in the 1939 session passed House Bill No. 857 to allow for the formation of non-profit medical service corporations. Under Section 2 of this bill medical services are not to be construed to include hospital services. The Insurance Commissioner must determine that the medical service corporation is in the public interest as in other states. The Insurance Commissioner passes upon the territory in which the corporation will operate, the services to be rendered and the rates to be charged therefor. The Insurance Commissioner may refuse to grant a permit for the establishment of such a medical service corporation if he shall find that the rates are excessive, inadequate or discriminatory. The Insurance Commissioner has broad powers of visitation and supervision over the activities of such a corporation.

*Summary.*—Except for the differences noted above the laws passed by these states enabling the incorporation of non-profit medical service plans have great similarity. However, it is only in the New York State statute that the words “Medical Expense Indemnity” are used. The statutes in the other states simply refer to the furnishing of medical service to subscribers under contracts, entitling the subscriber to such service and at the corporation’s expense. It is extremely significant that but one state, Pennsylvania, provides for supervision by the Department of Health to determine the quality of medical care which subscribers are receiving.

Despite the lack of enabling legislation, a number of similar plans have been established in other states. The California Medical Society has in operation a non-profit medical service corporation,

designated as the California Physicians' Service. Approximately five thousand of some seven thousand physicians engaged in active practice in California are professional members of this corporation. The physicians are reimbursed on a unit of service basis, which is determined by dividing the pool funds by the number of units of service. Thus—there is a periodic pro rata distribution of available funds.

Plans, such as the White Cross, have been established at Boston, Massachusetts, without specific enabling legislation: it consists of two parts—the patients' organization—Health Service, Inc., of Boston and the physicians' organization entitled Medical and Surgical Associates. Both groups have been promoted by certain public-minded physicians.

The following is a brief analysis of proposed legislation to allow for the establishment of medical service corporations in those states which failed to pass the proposed statutes.

*Arkansas:* In the State of Arkansas an attempt was made to make corporations which sought to furnish hospitalization and/or medical care subject to the law dealing with investment companies. Senate Bill No. 304 exemplifies that the legislator introducing this bill was of the opinion that plans were developing for the distribution of medical care and that there was need for control of such plans. Section 4 of this act states this point.

*Illinois:* House Bill No. 977 in Illinois, which failed passage, provided that the Director of Insurance should have the duty of approving and the supervision of a non-profit medical service corporation formed to distribute medical services or medical and hospital services to subscribers on a prepayment basis. It should be noted that this bill provided for the free choice of physicians by subscribers.

*Missouri:* In Missouri—House Bill No. 620, 1939, also failing to pass, provided that the Supervisor of Corporations should be authorized to be supervisor of the business of persons, co-partnerships, associations, organizations and corporations now doing business or incorporated to do business upon the plan of furnishing medical services, medical or surgical, or for hospitalization. This bill provided that compensation to any officer, trustee, stockholder or director should not be in excess of \$500 a year.

*Ohio:* Senate Bill and Sub-Senate Bill No. 104 of the 1939 Ohio legislative session, which failed to pass, specifically provided for approval and supervision by the Superintendent of Insurance of group medical service plans under which the corporations as intermediaries effected contracts between persons duly licensed to practice medicine and surgery in the State and persons, firms or corporations for the furnishing of medical or surgical care or both to subscribers for stipulated enrollment payments. An interesting point in this proposed bill was the provision that the majority of physicians in a certain area might prevent the Superintendent of Insurance from issuing a certificate.



*Utah:* In Utah an act was introduced into the 1939 Legislature, which failed passage, providing for the organization of non-profit medical or medical service corporations. The plans were to be under the supervision of the Commissioner of Insurance. This proposed statute differs from those in other states in the machinery by which attempts to secure financial solvency was set up. This bill provided that a corporation must have a minimum of one thousand subscribers at all times to stay in business. If the membership should fall below this number the Commissioner of Insurance might revoke the charter.

*Wisconsin:* One of the most interesting bills that failed passage was introduced in the Wisconsin Legislature in 1939—No. 401-A. It provided for a very interesting declaration of public policy:

“Section 1.—Declaration of Public Policy. The provisions of Sections 2 and 3 of this Act are essential to the welfare of the citizens of this state and are enacted in furtherance of the following public policy: The lives and health of its citizens constitute the first resource of a state. Proper medical care for the prevention, alleviation and care of illness is a prime necessity of life and health. The legislature finds and declares that large numbers of people in the state of Wisconsin are unable to secure adequate medical and hospital care because of insufficient means to meet the high cost thereof and because no arrangements exist for spreading the risk of medical and hospital expense over groups of people and periods of time. This inability to secure adequate care results in many cases of unnecessarily prolonged illness and permanently impaired health, thereby reducing the productive capacity of the state, impairing the general welfare, and imposing a burden on many individuals and on the community as a whole. The Legislature finds and declares that the cost of medical and hospital care can be reduced and regularized by the organization of cooperative associations to provide, secure or pay for such care, or by the furnishing of such care by individual physicians or groups of physicians under contracts providing for the payment of a stipulated sum per month, year or other period. It is therefore declared to be the public policy of this state to encourage and facilitate the formation of cooperative associations to provide or secure medical or hospital care, or both, and to encourage the furnishing of such care by physicians under contracts providing for the periodic payment of a stipulated sum.”

The title of the bill relates “to the formation of cooperative or other associations, to provide medical or hospital care, or both, discrimination against such associations, their exemption from insurance laws and providing a penalty.”

A specific section of Bill 401-A, 185-50, deals with medical cooperatives—it provides “. . . Associations may be organized on a cooperative basis: (1) by individuals for the purpose of securing or paying for medical and hospital care for themselves and their families; (2) by a group of physicians for the purpose of providing medical care.”

It further provides that such associations shall not be subject to the Insurance Law, and further that: ". . . and no provision of the law or chapter, or by-law of this state shall be construed to discourage or prevent physicians or hospitals from contracting with such corporations." This is evidently for the purpose of restraining medical societies or similar groups from interfering with physicians or hospitals who desire to join such cooperative organizations.

The relationship between physician and patient acting under a cooperative plan is codified as follows:

"In any case in which services are rendered by a physician pursuant to an arrangement of an association incorporated under this section, the personal and legal relation between physician and patient with all its incidents shall remain exactly as if the physician had been engaged by the patient directly, except as to the payment of the physician's compensation. In any case in which services are rendered by a hospital pursuant to an arrangement with an association incorporated under this section, the duties and rights of hospital and patient shall remain the same as if such arrangement with such association had not been made, except as to the payment of the hospital's charges."

It is specifically provided that members of cooperatives, whether they be patients or physicians, shall not be discriminated against in any way:

"No person shall be discriminated against, refused medical or hospital service or deprived of any of the benefits of the medical profession because of membership in, employment by, or a contract to serve the members of such association; and no physician shall be excluded from county medical society in the state on account of membership in, employment by, or a contract to serve the members of such association."

Any such interference is to be treated as follows:

"Any person, partnership, corporation or association, or any two or more of them, who shall directly or indirectly interfere with, or conspire to obstruct the organization or operation of any cooperative association organized pursuant to this section shall be guilty of a misdemeanor and upon conviction thereof shall be punished by a fine of not less than one hundred dollars nor more than one thousand dollars, or by imprisonment in the county jail for not more than nine months, or by both such fine and imprisonment, and any refusal of medical or hospital service to an individual because he is a member of such cooperative association shall be deemed *prima facie* evidence of such obstruction or conspiracy to obstruct."

What the legislator had in mind in drafting this legislation was to specifically permit the development of medical cooperatives and also the development of plans for medical or hospital service on the basis of a stipulated sum to be paid periodically. It was evidently his object to prevent boycotts by hospitals and state or

county medical societies or members thereof who were dissatisfied with the organization and development of such plans and wished to take steps which would prevent their being carried out by way of harrassing or working inconveniences on those involved, whether they be patient or physician.

### Description of Bills and Proposals for Compulsory Health Insurance

The following are brief analyses of these bills:

*The Model Bill of the American Association for Social Security*<sup>41</sup> (Epstein).—*Coverage Including Voluntary Clause:* A state-wide system of compulsory health insurance covering all employees subject to the state's jurisdiction who receive wages of less than \$60<sup>42</sup> per week except:

(a) Farm laborers and those employed in domestic or personal services where the employer has less than three such employees.

(b) Part-time employed minors who daily attend school.

Persons under 65 years of age not covered in the compulsory system and whose net earnings are not more than \$60<sup>42</sup> per week, may subscribe; fee is 3⅓ percent<sup>42</sup> of their income. Eligible also are persons receiving old age assistance or unemployment benefits, or relief from any governmental or public agency. The fee for this group shall be fixed by the Health Insurance Commission.

*Scope of Program:* (a) Medical services (to the insured and his dependents); (b) Cash disability; and (c) Cash maternity (to female employee and wife of employee).

*Scope and Amount of Medical Care:* Services of:

- |   |                             |
|---|-----------------------------|
| (a) General practitioners <sup>42</sup> | (e) Hospital care including |
| (b) Specialists <sup>42</sup>           | nursing                     |
| (c) Laboratory                          | (f) Limited dental care.    |
| (d) Clinic                              |                             |

These services are available to qualified employees and their dependents.

Benefits at the discretion of the Health Insurance Commission include drugs and medicine, nursing care outside the hospital, institutional care for convalescents, eyeglasses, orthopedic and other appliances.

#### Limitations:

1. Medical benefits begin three months after contributions accrue and become payable.

2. Eligibility continues so long as employee remains in covered employment.

<sup>41</sup> This bill on January 1, 1940, was in the process of being revised.

<sup>42</sup> This bill has been radically revised as of March 1, 1940. For Revision, see p. 402. 1940 changes in the "Epstein Model Bill" and Wagner New York State Compulsory Health Insurance Bill.



3. If he leaves employment or becomes unemployed he and his dependents remain qualified for medical benefits for a period equal to one day for every five days that he was covered by the system during the preceding five years.

**Benefit Restrictions:**

1. Hospitalization not to exceed 111 days in any one illness, 21 days of which are to be without charge and thereafter the recipient must pay 15 percent of the cost.

2. General practitioner care not to exceed a maximum of 26 weeks in any one disabling illness.

3. Specialists; clinic; laboratory. Services not to exceed 12 weeks in any one disabling illness.

**NOTE.**—Apparently there are no restrictions on the length of care in non-disabling illnesses.

Maternity benefits equal in amount to the benefits payable in disability would be paid to qualified women for six weeks before and six weeks after the birth of a child.

To obtain this benefit the woman must abstain from gainful work and have had not less than 250 days of employment or voluntary cash insurance during the two years previous to the day on which the benefit is to commence.

An additional \$15 maternity benefit for which all covered women are eligible is paid on the birth of a child if proper prenatal care has been received.

*Remuneration of Physicians:* No mode of remuneration of the practitioners may be adopted by any local area without the consent of the majority of the general medical and dental practitioners furnishing insurance services in the area.

General medical and dental practitioners may be remunerated in several ways: by salary, by per capita payments for each person on their list, by fee or by any combination of these.

*Scope and Amount of Cash Benefits:* There is a five<sup>43</sup>-day waiting period after the onset of illness following which the employee would receive<sup>43</sup> 50 percent of his full-time daily wages but with a maximum of \$15 a week for an employee without dependents and a maximum of \$22.50 per week or not more than 75 percent of his full-time wages.<sup>43</sup>

There are a number of qualifications which govern the eligibility for cash disability benefits and duration of such benefits.

*Administration:* The plan is to be administered by a "Health Insurance Commission"<sup>43</sup> composed of five persons;<sup>43</sup> the Commissioner of Health Insurance, the State Commissioner of Health and one representative each of employers, employees and of the professions engaged in furnishing the medical benefits.

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<sup>43</sup> For 1940 changes see p. 402.

The Commission is required to divide the State into a number of Health Insurance Districts each with its district financial supervisor and district medical supervisor—the latter a physician.

*Financing:* The cost of this system to be equivalent to 6 percent of the payrolls in covered payments, is to be borne jointly by employers, employees and the State as follows:

Wage of employees	Employees	Employers	State	Total
Less than \$20 weekly.....	1%	3½%	1½%	6%
\$20-39 weekly .....	2%	2½%	1½%	6%
\$40 a week or over.....	3%	1½%	1½%	6%

*The Wagner New York State Bill.—Coverage Including Voluntary Clause:* All employees excepting those engaged in non-manual work earning over \$2,500<sup>13</sup> per year. Voluntary insurance is provided for persons not covered in the compulsory scheme. This system is to be subsidized by the State to the extent of 20 percent.

*Scope of Program:* Both medical and disability benefits are provided.

*Scope and Amount of Medical Care:* Medical benefits consist of services of:

- |                          |                         |
|--------------------------|-------------------------|
| (a) General practitioner | (d) Clinic              |
| (b) Specialists          | (e) Hospital care       |
| (c) Laboratory           | (f) Limited dental care |

Services are available to both insured person and his dependents.

#### Limitations:

To be eligible, insured must have had 100 days of covered employment or voluntary medical insurance within the preceding 12 months, or 150 days within 24 months preceding the day medical benefits are asked for himself or his dependent.

Care is furnished without time limit so long as person through whose eligibility they are granted remains insured for such benefit.

Maternity Benefits are approximately the same as those provided for in the "Model Bill."

*Remuneration of Physicians:* There is to be free choice of general practitioners and dentists. This has not been specified for specialists. Physicians may be remunerated:

- |                                |   |
|--------------------------------|---|
| (1) By salary                  | (3) Per capita basis or any combination of these. |
| (2) On a fee for service basis |   |

*Scope and Amounts of Cash Benefits:* Cash benefits are to be paid to compensate for wages lost on account of disability at a rate of 50 percent of full-time wages with a maximum of \$20 per week. This benefit to be increased by an additional 10 percent of full-time wages up to \$5 per week for a dependent spouse and an

additional 5 percent up to \$3 per week for each dependent up to a maximum of four. A maximum of 156 days in each consecutive 52 weeks is the greatest extent of this benefit.

*Administration:* There is proposed a "Health Insurance Board" of five members, established as a Division of the State Department of Health. At least two members of this board shall be physicians. Provision is made for State general and medical advisory councils.

*Financing:* In its 1939 revision the bill calls for the following payments for the employee, the employer and the State. Contributions to fund (5 percent of total taxable wage) as follows:

Wage groupings	Employee	Employer	State	Total
Under \$20 weekly.....	1%	3%	1%	5%
\$20 and less than \$40 weekly	2%	2%	1%	5%
\$40 weekly or more.....	3%	1%	1%	5%

*The Changes Made as of March 1, 1940, in the Epstein Model Bill for Compulsory Health Insurance at the State Level.*—The following is an analysis of the revised Epstein Model Bill upon which is based the 1940 New York State Compulsory Health Insurance Bill, Assembly Introductory No. 1842, Print No. 2050, introduced by Assemblyman Wagner.

*Coverage Including Voluntary Clause:* The previous edition of the Epstein Bill applied to wage earners in the \$60 per week and less group. The Wagner Bill, 1939 edition, covers all employees excepting those engaged in non-manual work earning more than \$2,500 a year. The revised Epstein Bill and the 1940 Wagner Bill, which is based upon the "Model Bill," decreases the coverage to non-manual workers receiving wages of \$30 or less a week. Wage earners under an express contract for a term of not less than one year, at total wages for a year of \$1,500 or less are also covered. All other employees are covered except those engaged in agricultural labor, domestics in the service of an employer having less than three such employees, and minors actually and in regular attendance at day time in an institution of learning.

Where the earlier bills allowed for voluntary enrollment of persons under 65 whose net earnings were not more than \$60 a week, the revised bills limit such voluntary enrollment to persons under 65 years of age, not suffering disability, and whose net income from whatever source is \$30 a week or less. Such voluntary enrollees shall make weekly payments to the fund equal to three-quarters of the combined employers and employees premium as fixed for employees in the same wage class according to the revised premium schedule.

*Scope and Amount of Cash Benefits:* The earlier editions of the Epstein Bill and the Wagner Bill made use of a five-day waiting period, whereas the revised bills utilize a seven-day waiting period after the onset of illness before the insured employee is eligible to receive cash disability benefits. The cash benefits previously



outlined for the Epstein Bill are described on page 400 and for the Wagner Bill on page 401. The revised bills utilize the following cash benefit schedule:

TABLE 110  
CASH BENEFITS SCHEDULE

BENEFIT CLASS	When a person's weekly wage rate is	SUCH PERSON'S WEEKLY CASH BENEFIT AMOUNT SHALL BE			
		If he has no dependent	If he has one dependent	If he has two dependents	If he has three or more dependents
I.....	Under \$15.....	\$6 00	\$7 50	\$8 50	\$9 50
II.....	\$15 to 19.99.....	7 50	9 50	11 00	12 50
III.....	\$20 to 24.99.....	9 00	11 00	13 00	14 50
IV.....	\$25 and over.....	10 50	12 50	14 00	16 00

*Administration:* The previous Epstein Bill provided that the plan be administered by a health commission composed of five members. The 1940 revision provides for administration by a health insurance board composed of the Health Insurance Commissioner as chairman, the State Commissioner of Health and 13 members appointed by the Governor with the advice and consent of the Senate.

*Financing:* Under the earlier editions of these bills, the total premiums were to represent 6 percent of the total annual wage of those to be insured under the Epstein plan and 5 percent of such wages under the Wagner plan.

The new premium schedule which is being adopted for both the proposed bills is as follows:

TABLE 111  
PREMIUM SCHEDULE  
(Epstein Model Bill and Wagner New York State Bill)

WAGE CLASS	When an employee's weekly wage rate is	Employer's premium shall be	Employee's premium shall be	State's premium shall be <sup>44</sup>
I.....	Under \$15.....	40¢	10¢	60¢
II.....	\$15 to 19.99.....	40¢	20¢	50¢
III.....	\$20 to 24.99.....	40¢	30¢	45¢
IV.....	\$25 and over.....	40¢	40¢	40¢

<sup>44</sup> It is contemplated that the Federal government, through grants-in-aid, will reimburse one-half of the premiums required of the State. A bill for that purpose is now before Congress.

*Summary:* 1. The number of persons covered under the revised Epstein and Wagner Compulsory Health Insurance Bills has been materially lessened through the adoption of \$1,500 a year as the top income level for eligible non-manual workers and those under express contract for a term of not less than a year.

2. The 1940 revised premium schedule has discarded the use of a premium based upon a specified weekly percentage for employee, employer and State, which was based on the actual weekly wages received by the insured. Instead the insured wage earners are divided into four wage classes. For each of these wage classes the employer is to make a fixed weekly contribution of 40 cents per individual. The employee is to make a fixed weekly payment varying from 10 cents in the lowest wage class to 40 cents in the highest wage class. The State's weekly premium decreases from 60 cents weekly per wage earner in the lowest wage class to 40 cents weekly per wage earner in the highest wage class. It is further provided that the State's contribution may be decreased to one-half by the acceptance of Federal grants-in-aid to the State. A bill for that purpose is now before Congress.

3. The 1940 revised cash schedule, as shown above, is somewhat lower in general than the cash benefit schedule provided for in the previous editions of both the Wagner Bill and the Epstein Bill, the former having had a maximum cash disability benefit of \$20 per week and the latter a maximum of \$22.50 per week.

The waiting period before cash disability benefits become payable which had been five days in the previous edition of the Epstein Bill, has been increased to seven days in the new bill.

4. The revised bills make additional regular medical benefits available which include the services of nurses outside of the hospital. Voluntary insurance under the compulsory health insurance scheme has limited the persons eligible through a decrease from the \$60 or less per week income level to the \$30 or less per week income group.

5. The most significant administrative change in the new bill has been the increase in membership of the health insurance board from 5 to 15 members. Under Section I, part 4 of the revised Epstein Bill, "'Employee' means any person employed for hire by an employer in an employment subject to this act except any person employed under an express contract for a term of not less than one year at total wages for a year in excess of \$1,500, and except further any person employed at non-manual work receiving wages in excess of \$30.00 a week." In the second clause of this paragraph it appears that a mechanism is afforded whereby employers might evade insuring their employees whose incomes are in excess of \$1,500 per year through the use of a contractual agreement for terms of not less than one year. In the absence of such contracts such employees might otherwise be eligible for coverage by this system.

*The Wisconsin Biemiller Bill.—Coverage Including Voluntary Clause:* All employees except those engaged in agricultural labor or

domestic service (the latter, where employer has fewer than four persons in such service) and except persons engaged in non-manual labor who are paid at a rate of more than \$60 per week. The benefits would be available alike to insured persons and their dependents.

*Scope and Amount of Medical Care:* Medical benefits:

- |                                  |                           |
|----------------------------------|---------------------------|
| (a) General practitioner service | (e) Drugs and dressings   |
| (b) Specialist service           | (f) Laboratory service    |
| (c) Nursing care                 | (g) Clinic service        |
| (d) Hospital care                | (h) Optometrist service   |
|                                  | (i) Emergency dental care |

To be entitled to medical care, an individual must have had at least four weeks coverage during the previous 26 weeks immediately preceding the day on which health benefits are first provided. The covered person remains eligible so long as he is employed and for 26 weeks after last week of employment. In no event will health benefits be available to an eligible person for more than 26 weeks in any one illness.

*Scope and Amount of Cash Benefits:* There are no cash disability benefits. Medical care only is to be provided.

*Administration:* A "Division of Health Insurance" is to be set up in the State Department of Health. This division is to function under the supervision and control of the "State Health Insurance Council" appointed by the Governor and consisting of an equal number of representatives of each of the following: employers, employees, physicians, dentists, optometrists, pharmacists, hospitals and the general public.

The representatives of the professional groups are to be selected from panels proposed by their State Associations.

The Health Insurance Division is to be administered by a director appointed by the State Health Insurance Council and he is to be assisted by a medical officer selected by the Council from a panel of six or more physicians proposed by the State Medical Society.

Insured persons are to have free choice among physicians both general practitioners and specialists—dentists and optometrists, electing to provide insurance services.

All members of these professions are to have the right to participate in the work.

*Financing:* Employers and employees alike are to contribute 2 percent of wages paid and received. There is no contribution from the state.

*The California Bill.—Coverage Including Voluntary Clause:* Persons self-employed whose earnings are less than \$3,000 per year may subscribe. If a person is over 50 years of age he may not enroll as an individual but may enroll on a group basis.

*Scope of Program:* Service benefits include general practitioner's care, stipulated specialist services in keeping with the resources of the fund, but in any event to include major surgery, emergency specialist and obstetrical service, laboratory, x-ray diagnostic services, hospitalization up to a maximum of 12 weeks in any one



year in any one illness, and all drugs and medicines, nursing care and limited dental services as the funds permit.

*Scope and Amount of Medical Care:* To be eligible for medical benefits an individual must have earned at least \$300 in covered employments during the preceding calendar year.

*Remuneration of Physicians:* (a) General practitioner service rendered through an open panel system with free choice of physician who shall be paid on a per capita basis. The medical director may however engage physicians on a salary basis when necessary.

(b) Specialists services to be provided in public diagnostic centers to be organized throughout the state as adjuncts to public hospitals. Such services may be rendered also in approved private diagnostic centers coordinated with approved hospitals. Non-profit group practice is to be encouraged.

*Scope and Amount of Cash Benefits:* Reimbursement benefits consist of cash payments to eligible persons as part reimbursement of expenditures for medical services. Allowance is to be made on a prescribed fee schedule. Claims may be pro rated if they exceed amount set aside for reimbursement benefits.

*Administration:* The Medical Care Insurance Plan is to be administered by a "Bureau of Medical Service" established in a projected "Division of Social Insurance" in a state "Department of Social Insurance and Unemployment Services." A single agency within the department is to collect the contributions, maintain the records and do the disbursing of unemployment benefits, disability unemployment benefits and medical benefits. The head of the Bureau of Medical Service must be a physician.

There is to be Medical Advisory Council composed of eight members, three to represent labor, two employers and one each the physicians giving service, the Department of Health and the medical schools respectively.

*Summary:* The California Bill reveals the following outstanding differences from the "Model Bill":

1. Designed to take advantage of Federal aid.
2. The cash benefit portion of the projected health insurance is to be coordinated with the existent functioning unemployment compensation system.
3. The medical benefit part of the system embraces all employees within the state including state and local government employees, domestic servants, farm laborers and those of high incomes.
4. Source of income is 1 percent of taxable wages for employees, 1 percent from employers and 1 percent from the state (which may be reduced through Federal aid grants).
5. Medical benefits available to covered employees, spouse and children under 21 and are of two types:
  - (a) "Service benefits" provided for those earning less than \$3,000 per year.
  - (b) "Reimbursement benefits" to those earning more than \$3,000 per year.

## Chapter VII

### SPECIAL HEALTH PROBLEMS

Existing governmental agencies are organized to provide health and medical care services to meet special health problems involved in the control of certain specific diseases and conditions for which accepted control methods have been established and the public health importance to the communities transcends the consideration of the economic status of the individual. Each of the special health problems has been a subject of study by the State Department of Health which has responsibility for their administration. The control programs have been developed jointly with the representatives of organized medicine. Legislative consideration and support has been given to permit practical application of the developments in these specialized fields of modern medical science. This summary constitutes a brief progress report covering recent developments in these fields, and in some instances specific recommendations for the future. The factors involved in chronic illness and infirmity have been given special emphasis in the Commission's studies relating to medical care in welfare districts and patients discharged from hospital wards.

#### Pneumonia Control

The recent advances in the methods of treating pneumonia through the use of specific serum and the more recent development of the chemo-therapeutic drug sulfapyridine have provided excellent means of combatting a disease which accounted for some 12,000 deaths in 1935 in New York State. Especially significant is the fact that 40 percent of all the pneumonia deaths are of men and women in the economically most productive period of life, those from 15-64 years of age.<sup>1</sup> These deaths greatly disturb the economic stability of many families.

The modern adequate treatment for pneumonia includes: hospitalization; laboratory diagnostic service (including sputum typing, blood culture and drug concentration tests); physician's services, often including consultation and surgery; serum; oxygen; x-ray; drugs and nursing service.

From a comprehensive study<sup>2</sup> of the costs of diagnosis and treatment of 625 cases of pneumococcus pneumonia in New York City, the median total cost per case of pneumonia treatment for the entire group of patients including ward, semi-private and private cases, was \$134.16. Hospitalization accounted for 42 percent of the total

<sup>1</sup> Hirsh, Joseph, A Study of the Economics of Pneumonia, U. S. Public Health Reports, Vol. 53, No. 49, 1938, pp. 2153-2168.

<sup>2</sup> Cecil, R. L., et al, Community Provision for the Serum Treatment of Pneumococci Pneumonia. Journal American Medical Assoc. 109; 1323, Oct. 23, 1937.

costs for all cases; physicians' services 28 percent; serum therapy 16 percent and other services 14 percent. The average cost for this group was \$167.60 per case. On this basis more than 3.5 million dollars would have to be spent to treat the 22,000 cases of pneumococcal pneumonia estimated to have occurred during 1938 in New York City alone.

Many individuals find the treatment of pneumonia too expensive for them to bear. Governor Herbert H. Lehman launched a state-wide campaign for pneumonia control in January, 1936, because of the health and economic significance of the problem of pneumonia and the knowledge of efficient methods to combat this disease. A demonstration pneumonia control program was set up in the State Department of Health, supported jointly by public and private<sup>3</sup> funds. In one and one-half years this program demonstrated the effectiveness of rapid and positive means of identifying types of pneumonia. The possibility of production and use of efficient specific anti-sera to be employed in a generalized program to combat certain of the more common types of the disease was established. It was demonstrated that the mortality in certain types of pneumonia could be decreased by half or even by two-thirds.

In the eyes of a progressive State these results made additional support for this life-saving program almost mandatory and, on April 24, 1937, the Governor signed a legislative appropriation which made available to the State Department of Health \$400,000 for use in "furthering and promoting the efficient prevention, diagnosis, treatment and control of pneumonia."

The initial pneumonia control program of the State Department of Health concerned itself with:

1. The careful evaluation of the incidence, distribution and fatality of pneumonia.

2. Promotion of facilities for the accurate and prompt typing of pneumonias through sputum examination and blood culture.

3. Provision of a safe and reliable serum for each of the types of pneumonia for which serum has been found to be effective to all pneumonia patients irrespective of ability to pay. This serum was distributed through local supply stations to physicians and hospitals treating such patients.

4. Research in the production of effective specific sera for the treatment of various types of pneumococcus infection for which effective sera were not available; and improvement in the potency and quality of specific sera.

5. Education of both the physicians and the public as to the value of early use of the newer procedures and methods in the control of pneumonia morbidity and mortality.

The marked decline in the death rate from pneumonia seen during 1938 and 1939 has been of outstanding significance. This death rate is now at the lowest level yet recorded in the State.

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<sup>3</sup> The Metropolitan Life Insurance Company and The Commonwealth Fund contributed.



In spite of the decline in the death rate from pneumonia (85 per 100,000 in 1935 to 50 per 100,000 in 1938) this disease remains one of the principal causes of death. It is anticipated that still further reduction will be more difficult.

The current pneumonia program may be divided into two main efforts: continuation of the basic program of the past four years, with the extension of specific sera to approximately 30 types; and the effective utilization of the new agent, sulfapyridine.

The increased use of specific serum therapy in pneumonia is evidenced by the following reports for the distribution without charge of serum to physicians and hospitals by the State Department of Health as follows:

Anti-pneumococcus sera, all types

1936— 5,408 packages	1938—17,566 packages
1937—10,766 packages	1939—13,616 packages

In addition to the production of sera, the promotion of the development of approved laboratories for pneumococcus type differentiation and the maintenance of high standards of procedure in these laboratories, has been an essential part of the basic pneumonia control program.

In connection with the problem of laboratory service, a brief inquiry<sup>4</sup> was made during the latter part of 1939 of all laboratories approved for pneumonia typing, as to the number of examinations performed by them during 1937-1938 and the sources of reimbursement for such examinations. While the material from this survey is not yet complete, the evidence at hand indicates that in the majority of instances typing is done either by laboratories operating under county or city contract or charter, or by laboratories associated with hospitals where work is done for service cases at no cost over and above the general hospital rate. The laboratories report that the amount of typing for which the charges were paid through local welfare agencies was very small. This investigation revealed only one specific complaint that typing was not being carried out in a given community because of the difficulty associated with obtaining reimbursement in indigent or medically indigent cases. However, neither was evidence obtained to the effect that such difficulties did not constitute a widely encountered obstacle to typing service. Furthermore, it was found that many of these laboratories are operating under contracts or sources of revenue which have not changed in proportion to the increasing demand upon their services imposed by such activities as the pneumonia and syphilis control programs. In connection with pneumococcus typing, not only has the volume of specimens been greatly increased over the past four years, but also the total amount of work required for the complete examination of each specimen has been greatly extended.

<sup>4</sup> Bureau of Pneumonia Control—State Department of Health—February, 1940.

The basic pneumonia control program also includes the maintenance of a high level of information and interest among the medical profession in the scientific advances in the treatment of pneumonia, as well as in the principles underlying modern treatment. This is promoted through the joint action of the Bureau of Pneumonia Control and the Committee on Public Health and Medical Education of the State Medical Society. Similarly, appropriate informational and educational programs are being maintained for the nursing profession and for the general public; the former being directed to the scientific information of nurses and the promotion of essential nursing services; the latter to the recognition of the early symptoms of pneumonia and the urgency of obtaining medical care.

Major advances in the treatment of pneumonia have been so numerous during the past few years that it has become a practical impossibility for the physician in general practice to keep adequately acquainted with them. This is particularly true of chemotherapy. Accordingly, the Bureau of Pneumonia Control has felt that its efforts to conduct an active graduate medical educational program, in collaboration with the State Medical Society, should be redoubled.

Inasmuch as sulfapyridine is not expensive and the Department of Social Welfare has agreed to include it among its recommended drugs, so far it has seemed unnecessary for the Health Department to undertake the distribution of sulfapyridine. The drug, however, is not without serious danger if improperly used. These dangers are such that, upon recommendation of the Health Department, a regulation has been adopted by the Board of Pharmacy of the Department of Education, restricting the sale of sulfanilamide, sulfapyridine and allied compounds to physicians' prescriptions.

To date the approach to the problem of pneumonia control, of necessity, has been restricted to reduction of mortality, and duration and severity of pneumonia. The therapeutic approach has not been taken in preference to one of prevention, but rather has been necessitated by lack of means for accomplishing the latter. It is felt, now that highly effective means of treatment are available, and the death rate is steadily declining, that every opportunity should be utilized to investigate the mechanism of spread of this disease with a view to the possible development of preventive measures.

### Cancer Control

A steady increase in mortality from cancer and other malignant tumors has been noted both in New York State and the United States from the time statistics on the causes of death were first collected. The risk of developing cancer increases sharply and markedly with advancing age. It is therefore to be expected that the increasing proportion of older people in our population will of itself make for increasing cancer mortality. It is encouraging to

note that when this effect, of aging of the population, is eliminated from the figures there appears a tendency in recent years for the cancer death rate among females to remain stationary or even to decline among the younger age-groups. On the other hand signs of such a decline does not appear in the death rate among males. Cancer is now the second cause of death and will probably continue in this position for many years.

While much is already known and new facts are constantly added concerning the experimental causation of cancer in animals, little of this knowledge is as yet applicable to the control of cancer in humans. Cancers resulting from repeated exposure to such agents as tar, lubricating oils, arsenic, anilin compounds, various carcinogenic chemicals, roentgen-rays, radium rays and ultra-violet rays are known to occur in man and are preventable. However, the number of cases traceable to these causes is small. A causal relationship between syphilis and certain forms of oral cancer is known to exist but the majority of cases of oral cancer cannot be so explained. Much stress has been placed, in public education, on certain non-specific causes of cancer, such as poor oral hygiene, the use of tobacco, the ingestion of hot foods or alcohol, laceration of the uterine cervix, chronic cervicitis, chronic mastitis and chronic irritation in general. It must be admitted, however, that the evidence regarding the causal relationship between these conditions and cancer, although highly suggestive, is not entirely convincing and does not find general acceptance. In general what is known concerning the causes of cancer offers greater hope of usefulness in the detection of early cancer rather than in its prevention.

In the absence of precise and well-authenticated knowledge regarding the efficient causes of the major types of human cancer, the basis of cancer control must be the relatively lower case fatality obtained when cancer is recognized and treated before metastasis has occurred. The State Commissioner of Health has estimated that even partial improvement in this direction will result in the saving of over 5,000 lives each year in this State.<sup>5</sup>

The necessity for early diagnosis in order to achieve lower case fatality rates is alone sufficient to make cancer a public health problem. Experience has shown that some form of organized effort is necessary to promote early diagnosis of diseases such as cancer whose early stages produce mild or no symptoms. Moreover, the special facilities often needed to treat cancer are frequently not available to the average physician, while the great expense of treatment makes aid to the low-income group necessary. The difficulty of early diagnosis, the lack of easy access to expert diagnostic and therapeutic facilities, the relatively high expense of these facilities, combined with the lack of the natural spur of pain and disability in the early stages of cancer, combine to explain the present rarity of early diagnosis and effective treatment of this disease. To overcome these obstacles in the way of early diagnosis

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<sup>5</sup> Edward S. Godfrey, Jr., *The N. Y. State Program for Cancer Control*; *N. Y. State J. of Medicine* 39; p. 2280; Dec. 15, 1939.



and treatment requires an organized, planned, community-wide program or, in other words, public health measures.

The State of New York has long extended its aid in the struggle against cancer. In 1898, the State Legislature granted the sum of \$10,000 for laboratory study of cancer and from this small beginning has developed the State Institute for the Study of Malignant Diseases in Buffalo, New York. During its first 12 years the Institute confined its efforts to laboratory research. At the end of that period it was decided to extend the research to clinical aspects of cancer and especially the results of radiation therapy. A 22 bed hospital adjoining the laboratory was erected and to this Institution any physician in the State may send patients for diagnosis and treatment without charge.

The number of patients referred to the Institute by physicians has increased steadily with each succeeding year so that in recent years the facilities of the Institute have been severely overtaxed. This condition came to the attention of several members of the Legislature and in 1937 a bill was introduced providing for the erection of an additional hospital to increase the Institute's bed capacity by 100 beds, and provision was made for the purchase of sites for two additional hospitals. In view of the fact that it was not certain that the building of additional State cancer hospitals was the best answer to the problem, it was deemed wise and the legislation accordingly amended so that, while expanding the facilities of the Institute by the addition of 100 beds, the general question of cancer control was submitted to a legislative commission for study and recommendations regarding legislative action.

This Commission submitted its final report in February, 1939, and legislation based on its recommendations was passed shortly thereafter and subsequently received the Governor's signature. The bill was passed substantially as recommended, with the exception that the appropriation for the newly reorganized Division of Cancer Control was reduced from \$50,000 to \$35,000 and the provision for reporting of cancer was limited to New York State, exclusive of New York City.

In accordance with the provisions of the bill<sup>6</sup> the Division of Cancer Control which had been organized in 1931, with headquarters at the State Institute for the Study of Malignant Diseases, Buffalo, was reconstituted with headquarters at the central offices of the Department of Health in Albany. The law specifically provides that the Director of the Division shall not be expected to assume also the full-time duties of Director of the State Institute.

The reorganized Division has been functioning since August 1, 1939. Reporting of cancer began on January 1, 1940, and at the end of April, 1940, 13,345 cases had been reported by physicians, dentists, hospitals and laboratories. Cancer reporting will not only make available information regarding the incidence of cancer and its relation to various social, geographical, occupational and economic factors but it will provide also an index to the effective-

<sup>6</sup> Chapter 954, Laws of 1939.

ness of control measures and indicate what sections of the population and what forms of cancer require the greatest attention and application of such measures as education and the establishment of tumor clinics.

There are now 33 tumor clinics in Upstate New York, of which two are diagnostic clinics, while the remainder are both diagnostic and therapeutic. Many hospitals and groups of doctors are interested in the tumor clinic idea and those which are functioning as clinics and those which are in the process of establishment total 42. These clinics will amply take care of the cancer patients in Upstate New York without necessitating their traveling more than 50 miles and in most instances the distance will be much less. They are conducted by the medical staffs of the different hospitals with the result that more adequate care is available to the patients and the care and control of these patients is kept under the jurisdiction of the practicing physicians. This plan affords to the physicians opportunity to participate in the care, diagnosis and treatment of their cancer patients.

An educational program, both for profession and lay groups, will be sponsored by the Division of Cancer Control. Professional education will be in the form of institutes for general practitioners, surgeons, radiologists and pathologists. The various county medical societies cooperating with the Division will conduct the lay education. It is hoped that lay education will cause patients to seek aid early in their disease thus affording an opportunity for early diagnosis, more cures, and better control of the disease.

To a considerable extent the problem of cancer control is involved with the much broader problem of making generally available the best kind of medical care. This is due to the fact that: early cancer frequently causes no symptoms; and, when symptoms first appear they are not characteristic of cancer but simulate those caused by a wide variety of other diseases. The early diagnosis of cancer, therefore, inevitably involves the early diagnosis of many other diseases of adult life.

It is generally agreed and, indeed it has been demonstrated in actual practice, that expert examinations of apparently healthy adults will discover many cases of unsuspected cancer as well as other chronic diseases. As a rule cancer discovered in this way is usually in an early stage and highly curable. How to make use of this principle in a broad and effective way is one of the most important questions facing those concerned with the problem of cancer control. Of equal importance is the problem of ensuring that adequate therapeutic facilities are readily available to physicians and their patients once cancer has been discovered. Obviously the barriers in the way of solution of these problems are social and administrative, rather than scientific.

It may, therefore, be confidently expected that, in view of the great toll of suffering, disability and death exacted by cancer, progress in the effective application of the scientific weapons we already possess for its early diagnosis and adequate treatment will continue at an accelerated pace in New York State.

## Syphilis Control

Syphilis control can be attained by finding cases early and treating each patient until he is no longer capable of transmitting the disease to others. Were this possible early in the course of every person's infection, no other measures would be necessary. As it is there are many late or chronic cases, not a problem from the standpoint of communicability, who tend to become public charges as a result of the disease. Their treatment is essential to keep them potentially self-supporting.

In this effort there are many agencies engaged: the private physician; the hospital; the clinic of the local board of health; the clinics of some large industrial organizations; the State Department of Health or the State mental hospital—may each have a hand in the care of a patient. At the outset, the diagnosis is made of necessity with the aid of a laboratory test. Because this is too highly technical for performance in a physician's office or small laboratory, these tests are performed without charge by the State Department of Health or one of 33 approved laboratories partly financed by the State. In 1937, 386,102 such tests were performed by the laboratories of the State Department of Health and 410,505 by the laboratories approved by the State Department of Health.

The diagnosis made, treatment is administered each week for at least 18 months. The drugs for such treatment, costly in small quantities, are supplied to physicians by the State Department of Health without charge, irrespective of the patient's ability to pay. During 1937 the equivalent of 625,000 doses of such drugs were distributed to physicians, clinics, and hospitals. But because most patients with syphilis are in the low-income groups, they are frequently unable to finance the long period of treatment. Some are treated by the physician without charge. Others are referred to the clinic of the local board of health. At the end of 1937 there were 125 of these clinics in 40 counties. During the year 4,458 patients were admitted to these clinics for the first time; while 5,542 continued treatment begun prior to 1937; 237,187 anti-syphilitic treatments were administered; and 81,567 other visits were made for diagnosis or observation.

In areas where clinics are too distant for the patient to attend each week other solutions have been sought. Treatment in clinics is not economic where the total number of cases is small, and the provision of transportation by an official agency has proved prohibitively expensive. One of the duties of the local health officer established by the Public Health Law (Art. XVII-B, Sec. 343-p) is the treatment of venereal disease. While this has operated well in some areas, it has not been effective in others. To cover this deficiency the payment of private physicians for the treatment of indigent patients has been adopted by some counties. At the end of 1937 there were four or more counties using this plan. Under this arrangement any physician whose indigent patients require treatment may request authorization for such treatment and be compensated by the county on a unit sum per treatment basis.



This not only leaves the patient his free choice of physicians but obviates the necessity for excessive travel.

In counties where this plan is not in use, varying expedients are employed. In addition to the duty of the local health officer alluded to above, the Public Welfare Law, Article X, Section 83 provides that persons unable to pay for medical care, even though otherwise self-supporting, may be treated at the expense of the local welfare district. The absence of a clear definition in the law of the respective duties of the local board of health and the local welfare district has sometimes led to a disavowal of responsibility by both. In those areas frankly indigent or medically indigent cases with syphilis in the chronic or non-communicable stages may go untreated at the risk of later becoming patients in local hospitals or State mental hospitals.

In some areas the local welfare officer has authorized treatment on a fee basis by private physicians selected by the patients. This practice has varied widely from year to year, from one welfare officer to another, and from one welfare district to the next, both as to the type of patient eligible for treatment, the amount and type of treatment, and the compensation allowed to the physician. As an example, in an area chosen for study, anti-syphilitic treatment by the private physician is authorized for persons receiving old age relief, but for no others, whatever the stage of the disease or the urgency of treatment. The local boards of health also vary in the extent to which they are willing to assume their legal responsibility for the treatment of syphilis. Such intricacies have tended to reduce the amount of effective treatment and so to increase the number of persons eventually disabled by syphilis.

The general hospital has been mentioned as an agency for the provision of anti-syphilitic treatment. Only a few general hospitals have provided treatment for the patient in the early stages of syphilis because of the prejudice against this practice on the part of other types of patients cared for who are more frequently able to pay for their general hospital care. A large number of late cases with disabling forms of the disease fall upon the general hospital for care during the last stages of failure of the heart or blood vessels. This number is uncountable because of a tendency to ascribe death to other causes than syphilis for social reasons. As an indication 1,416 deaths reported as due to syphilis were recorded in 1937. This number is probably far below the true figure.

The mental hospital comes into the picture in a proportion of all cases of syphilis estimated at from 10 to 40 percent. One of the various diseases of the nervous system caused by syphilis, general paresis, requires institutional care if treatment is not properly administered before mental breakdown occurs. During the fiscal year 1937-1938, 3,944 patients with general paresis were cared for in New York State mental hospitals. The capital investment in hospital accommodations for this number of patients amounts to \$14,198,400. The annual cost of maintenance of these cases amounted to \$2,604,341.52. No estimate of the cost of the

maintenance of the families of these patients by public agencies is available. In the opinion of some experts, most of these patients (40-80 per cent) could have been kept potentially self-supporting by early and adequate treatment.

*Syphilis Clinics.*—While no clinics are wholly maintained by the State Department of Health, it supervises and assists the 122 clinics which operate under local boards of health. At the end of 1937, 21 cities and three other local health districts were receiving financial aid from the State Department of Health, amounting to a total of \$81,000 for the fiscal year. Part or all of the salaries of 67 physicians and 10 nurses employed in syphilis clinics were paid by the State. Because many of these physicians were without special training in the diagnosis and treatment of syphilis, six part-time and one full-time consultant physicians conversant with syphilis were employed to assist and instruct the local physicians who actually perform the work of the clinics.

In furtherance of the objective of post-graduate instruction of physicians treating syphilis, short refresher courses were held in New York City, Buffalo and Syracuse. These courses lasted three days and were attended by 91 local health officers and directors of syphilis clinics, all of whom received stipends from the State Department of Health to cover traveling expenses.

The instruction of public health nurses engaged in syphilis control was furthered by a six-week post-graduate course at Syracuse University. Thirty-six nurses attended this course in 1937 at State expense.

*Case Reports.*—Since the detection of a complement-fixation reaction in the blood (the laboratory test referred to in the foregoing material) does not necessarily mean that the individual in question has syphilis, it is required by the Sanitary Code (Chap. II, Reg. 2) that judgment concerning such cases rest with the attending physician and that if in his opinion syphilis exists, he shall report the case, including details of identification and the stage of the disease, to the State Department of Health. These reports are utilized by the District State Health Officer to maintain a file of the cases in a communicable stage. These cases are followed through the attending physician until sufficient treatment has been administered to ensure against transmission of the disease. In the event of the patient's change of residence or physicians the records are transmitted to the proper District Health Officer or physician to ensure the completion of a sufficient amount of treatment.

The risk of the transmission of syphilis to the unborn child from an infected mother is present in each pregnancy, whatever the amount of treatment before conception. This risk can be greatly reduced by treatment during the pregnancy. To increase the probability of the discovery of syphilis early in the course of pregnancy, it was provided March 18, 1938, in the Public Health Law, Section 383-a, that a serological test for syphilis be performed on

every pregnant woman the first time she visits a physician in that state.

The Domestic Relations Law was amended April 12, 1938, to require a physical examination and serological test for syphilis of every applicant for a marriage license. The issuance of a marriage certificate to any applicant who, in the judgment of the physician to whom he applies for examination, has syphilis in a communicable stage is forbidden. The reports of such cases are followed by the District State Health Officer in the manner described above, until the patient has received sufficient treatment to render him non-infectious.

*Public Health Education.*—The publicity accorded to syphilis by means of the radio, the press, the motion picture, posters and public speakers is too well known to require discussion, but is recognized as an essential part of the syphilis control program.

### **Tuberculosis Control—With Special Reference to Hospitalization**

The hospital treatment of tuberculosis patients should not be looked upon as a service only to the individual. Such hospitalization is a public service which protects the patient's family and the general public, and is essential for the control of tuberculosis. Where the 1930 Health Commission had as its major recommendation the construction of new State tuberculosis hospitals, the present Commission has reviewed the problem of hospitalization of persons suffering from tuberculosis.

*An Inventory of the Tuberculosis Hospitals.*—The bed capacity of tuberculosis hospitals located throughout New York State, exclusive of New York City, totals 5,537, of which 1,149 beds are located in the four State tuberculosis hospitals, 3,567 in county tuberculosis hospitals, and 821 in municipal tuberculosis hospitals. The total number of beds in these 34 official tuberculosis hospitals is 5,537 as compared with 2,297 deaths from tuberculosis in 1938—a ratio of 2.4 beds per death. In the opinion of some experts, a desirable ratio of the number of beds per annual death of tuberculosis is three beds per death. A ratio of two beds per death, however, should be the minimum. A study of existing beds in county and city tuberculosis hospitals reveals that this ratio varies from 5.5, which is the highest ratio in one county, to 1.1. However, there are only six counties in the State which have a ratio of less than two beds per death, namely—Albany, Orange, Ulster, Cattaraugus, Erie, Fulton and Montgomery.

*Investment and Operating Costs of Tuberculosis Hospitals.*—The present amount of the capital investment of the 30 county and city tuberculosis hospitals is estimated at twenty-one million dollars, with an annual expenditure of four million three hundred thousand dollars for maintenance. In addition, the four State tuberculosis hospitals represent an investment of approximately five and one-half million dollars with an annual operating cost



of slightly over one and one-half million dollars. The total investment of tuberculosis funds in tuberculosis hospitals, exclusive of New York City, is, therefore, about twenty-seven million dollars, with an annual operating cost of more than six million dollars.

*The Sources of Financial Support.*—There is a wide diversity in the source of funds used for the operation of tuberculosis hospitals within the State. In the original development of tuberculosis hospital facilities, the counties and cities assumed the responsibility for the construction and maintenance of the hospitals. The expenses of hospitalization for patients from neighboring counties not having a tuberculosis hospital and who were unable to pay, were charged back to the county of their residence.

*State Tuberculosis Hospitals.*—In 1902 the State established its own sanatorium for incipient tuberculosis patients at Raybrook. This hospital was designed to serve the whole State. A very small charge was made to the localities who referred patients for treatment there. In general the counties were extremely lax in paying this charge and it has been discontinued. During the period from 1932 to 1938 three new tuberculosis hospitals of 200 bed capacity each were constructed and the capacity of the Raybrook State Hospital was increased. Three State hospitals are designed to serve those counties in the State which do not maintain their own tuberculosis sanatoria. Two dollars and fifty cents a day toward the cost of hospitalization for those patients unable to pay is charged back to the county.

*County Tuberculosis Hospitals.*—With the development of full-time county departments of health which are eligible by law for a 50 percent reimbursement of their cost on a State-aid to county basis, the State assumed responsibility for half the operating expenses of tuberculosis hospitals located in several of those counties maintaining county departments of health. During 1939 State-aid to counties for the maintenance of tuberculosis sanatoria was rendered to the following counties: Cattaraugus, \$23,900; Columbia, \$31,469.50; and, Suffolk, 68,605. Westchester County, while maintaining a County Department of Health, does not receive State-aid for its tuberculosis sanatorium because the tuberculosis sanatorium is under the administration of the County Welfare Department. Likewise, Nassau County does not receive State-aid on its sanatorium. The remaining 21 counties maintaining tuberculosis sanatoria do not receive State-aid toward the operation of their tuberculosis hospitals.

*City Tuberculosis Hospitals.*—Buffalo and Yonkers both maintain tuberculosis sanatoria, the support of which is at present a full responsibility of the respective cities.

*Utilization of Hospital Beds.*—As a result of many factors, the most important of which is in the reduction in the death rate, as well as the reduction in the incidence of tuberculosis in the population, some counties are not fully utilizing existing tuberculosis

bed facilities, in consequence of which there is a relatively large number of vacant beds, while other counties, and especially the larger ones, are woefully lacking in sufficient facilities to meet the present demands.

Patients, especially in Buffalo, in Westchester County and in one or two other counties, are unable to secure prompt hospitalization because of inadequacy of bed facilities, while under the present system vacant beds prevail in neighboring counties or sections of the State. Many hospital beds are at present occupied by patients who might safely be transferred to their homes thus allowing the use of such beds for open infectious cases.

This maldistribution and malutilization of tuberculosis hospital beds in Upstate New York is a major problem. Table 112 shows the distribution of counties by percentage decline in the death rate from 1926 to 1938. Table 113 shows the percentage utilization of beds by adult patients in relation to the total number of beds available. These tables are on pages 420 and 421.

There is no question but that there are a sufficient number of cases of tuberculosis throughout the upstate area to occupy all the available beds. However, economic, social, industrial and domestic influences deter many patients from accepting hospitalization.

Some of the county and city tuberculosis hospitals render services of such poor quality that they fail to secure a full return on their investment for tuberculosis control. A tuberculosis hospital may be said not to adequately serve the area under its jurisdiction unless it utilizes adequate modern diagnostic and therapeutic equipment and has an active case finding and case follow-up service.

Many of these hospitals have facilities, usually in separate buildings, for the hospitalization of children. A vast majority of the beds so used have been of the so-called "preventorium" type. Recent studies, however, indicate that the hospitalization of children in preventoria does not materially contribute to the control of the disease, and that children, except those with active tuberculosis, or those whose home contact with an open case of tuberculosis cannot otherwise be broken, do not need this form of treatment. Adequate environmental surroundings may be provided for children formerly hospitalized in preventoria in a much more economic way. On the other hand, most of the hospital facilities previously used for children can, with minor building alterations, or remodeling, be made suitable for the hospitalization of adults. At the present time, 21 of the 30 county and city tuberculosis hospitals are utilizing less than 90 percent of their beds for the hospitalization of adults. Of this group, 13 are utilizing less than 75 percent of the available beds for this purpose.

*Future Reallocation of Hospital Beds May be Necessary.*—Should the tuberculosis death rate continue to decline it will be necessary for public authorities to arrange for a more effective utilization of available hospital beds for tuberculosis, so that

areas of large population with higher death and case rates from tuberculosis may have the use of a sufficient number of beds, and the smaller areas may be served by larger and better equipped hospitals.

TABLE 112

New York State (Exclusive of New York City)

TUBERCULOSIS CONTROL — WITH SPECIAL REFERENCE TO HOSPITALIZATION  
PERCENT DECLINE IN RESIDENT TUBERCULOSIS DEATH RATE  
BETWEEN 1926 AND 1938

Area	Percent decline 1926-1938
New York State.....	43.4
New York City.....	39.7
Total upstate.....	49.3
Urban upstate.....	52.7
Rural upstate.....	49.7
31 counties included in 4 State tuberculosis hospital districts.....	56.5
26 upstate counties included in State tuberculosis hospital districts...	52.1
Fulton County.....	31.6
Erie County.....	36.3
Suffolk County.....	43.8
Herkimer County.....	43.9
Nassau County.....	44.8
Oswego County.....	46.9
Albany County.....	48.4
Dutchess County.....	50.0
Niagara County.....	50.0
Onondaga County.....	50.0
Cattaraugus County.....	50.9
Montgomery County.....	51.1
Orange County.....	51.2
Ulster County.....	53.0
Oneida County.....	54.1
Schenectady County.....	54.8
Westchester County.....	55.3
Rensselaer County.....	56.0
Broome County.....	56.1
Rockland County.....	57.0
Saratoga County.....	57.1
Columbia County.....	57.4
Warren County.....	58.2
Monroe County.....	60.1
Chautauqua County.....	61.3
Jefferson County.....	67.0



TABLE 113

New York State (Exclusive of New York City)

TUBERCULOSIS CONTROL — WITH SPECIAL REFERENCE TO HOSPITALIZATION  
 PERCENT UTILIZATION OF TOTAL AVAILABLE BEDS<sup>1</sup> BY ADULTS IN  
 THE COUNTY AND MUNICIPAL TUBERCULOSIS HOSPITALS  
 LOCATED OUTSIDE THE STATE TUBERCULOSIS  
 HOSPITAL DISTRICTS, 1938

Hospital	Percent utilization of total beds by adults
Dutchess County.....	57.3
Broome County.....	59.6
Suffolk County.....	62.2
Oswego County.....	64.1
Niagara County.....	64.3
Chautauqua County.....	64.7
E. J. Meyer (Buffalo City).....	66.1
Herkimer County.....	69.4
Columbia County.....	70.4
Grasslands (Westchester County).....	71.1
Jefferson County.....	71.2
Nassau County.....	72.5
Oneida County.....	72.9
Rensselaer County.....	76.5
Onondaga County.....	77.8
Montgomery County.....	78.0
Monroe County.....	79.1
J. N. Adam (Buffalo City).....	81.9
Saratoga County.....	82.9
Cattaraugus County <sup>2</sup> .....	85.9
Warren County.....	87.5
Grey Oaks (Yonkers City) <sup>2</sup> .....	92.9
Rockland County <sup>2</sup> .....	94.2
Ulster County <sup>2</sup> .....	94.2
Orange County <sup>2</sup> .....	98.1
Schenectady City.....	98.3

<sup>1</sup> Includes all adults' and children's beds.<sup>2</sup> No children's beds available.

From the standpoint of public economy, it will be necessary to devise some method whereby the costs of hospital care for tuberculosis patients may be paid for so that patients may be moved from one area to another with the elimination of the restrictive and burdensome reimbursement methods which now exist.

Further, the development of surgical services for the care of tuberculosis patients, which are now provided in the State tuberculosis hospitals and which is a highly specialized branch of modern treatment, should be available to all tuberculosis patients needing such type of treatment. It seems urgent that a system be developed whereby patients being cared for in sanatoria not equipped to render surgical care and other specialized treatment may be sent to a State hospital when in need of this care. This referring mechanism should not be hampered by the existence of county boundaries.

*Economic Factors in the Hospitalization of Tuberculosis Patients.—Public Welfare Law:* Differences exist between the Public Welfare Law, County Law and State Public Health Law relative to the administration and determination of ability to pay for care of patients suffering from tuberculosis.

Public Welfare Law, Section 86, reads as follows:

“The public welfare district shall likewise provide suitable care for patients suffering from tuberculosis in a county or city tuberculosis hospital or in any other hospital or sanatorium approved by the state board of charities or in a boarding house approved in writing for this purpose by the health officer in charge of the locality where it is situated.

“In a public welfare district which has no tuberculosis hospital, the commissioner, upon receipt of a written application accompanied by a certificate of a reputable physician, stating that he has examined such applicant within ten days next preceding and that such applicant is, in his judgment, suffering from tuberculosis, may apply to the superintendent of any tuberculosis hospital for the admission of such patient. The commissioner shall furnish a blank to be used by physicians for such certificates.

“The commissioner may apply for admission to the New York state hospital for the treatment of incipient pulmonary tuberculosis on behalf of any patient suffering with tuberculosis in an incipient stage, or suspected of having tuberculosis in an incipient stage. Applications and admissions to such hospital shall be made in accordance with the provisions of the public health law, and regulations of the state commissioner of health.”

*County Law:* The County Law, Sections 45 to 49-E provide for the administration of county tuberculosis hospitals. Under Sections 49 and 49-A of this law, any resident of the county in which the hospital is situated may make application to the superintendent or any physician for the admission to the hospital. Should the superintendent upon receipt of such application decide that the patient is a suitable one for treatment or diagnosis in the hospital, the patient is admitted. Provision is made on the application form for the referring physician to state whether in his judgment the patient is able to pay in whole or in part for his care. Following admission the superintendent shall cause inquiry to be made as he may deem necessary regarding the ability of the patient's relatives to pay. If in his judgment a patient can pay in whole or in part for the treatment, he is required to do so.

*State Public Health Law.*—Sections 339 and 340 of Article 16-A contain provisions whereby application for admission of patients to the State tuberculosis hospitals from the counties in the prescribed areas of such hospitals is made according to a procedure similar to the one provided for in the County Law. After admission of the patient, the superintendent of the State tuberculosis hospital shall cause an inquiry to be made as to the patient's

or his relatives' ability to pay for his hospital care. If in his judgment they are not able to pay, the bill is sent the first of the following month to the clerk of the board of supervisors.

*Confusion in the Administration of These Laws:* Section 86 of the Public Welfare Law is evidently an outgrowth of the original Chapter 733 of the Poor Laws adopted in 1872. Originally the purpose of this law was to provide hospital care for indigent persons suffering from tuberculosis, although its scope is now extended by Section 83 of the Public Welfare Law.

Under the County Law the determination of ability to pay for hospitalization is a responsibility of the superintendent of the county hospital; the local welfare commissioner is not mentioned in this connection.

The intention of the Public Health Law, with reference to the maintenance of State tuberculosis hospitals, was a similar change of responsibility for the determination of ability to pay from the local welfare officers to the superintendent of the State tuberculosis hospital.

Largely because of the confusion in the interpretation of the relevant provisions of the Public Welfare Law, the County Law and the State Public Welfare Law, patients who are not definite indigents in many counties sometimes have a difficult time in securing hospitalization. It has been reported that there are a few counties where all approval for tuberculosis hospitalization is delegated to the county commissioner of welfare. Under this arrangement many of the patients are not provided with hospitalization unless they are indigents or unless small family resources are expended for hospital care, which in turn may result in families becoming indigent. It has been further reported that in the few counties in which there is a county tuberculosis hospital established under the County Law, the county welfare commissioner or the local supervisor or town welfare officer passes upon the hospitalization of cases of tuberculosis admitted under the provisions of the County Law.

This practice of placing hospitalization of tuberculosis on a welfare rather than a public health basis is reported to have a serious direct and indirect influence on the control of the disease. This influence may be felt in the following ways: first, in postponing the admission of patients early in their disease when treatment not only is less costly but also when the chance of recovery is much greater; second, it increases the opportunity for the spread of the disease in the home and elsewhere due to postponing or preventing the isolation of infectious cases; and, third, particularly in small communities, the information from patients that their families must surrender life insurance policies, increase their mortgages, sell some of their cattle, or in other ways exhaust families' small resources acts as a definite deterrent to other patients who may require hospitalization.

These conditions which prevail in the few counties where decision as to financial eligibility of patients is made by public welfare



officials are reported to be retarding the progress made in our State tuberculosis hospital areas. Although there is no specific provision in the Public Health Law requiring it, the county boards of supervisors refer case reports of patients hospitalized in the State tuberculosis hospitals to the local welfare department for investigation, decision and collection.

The hospitalization of cases of tuberculosis should not be considered primarily as making provision for medical care on the same basis as is provided for medical care by welfare officials for most other diseases. The hospitalization of patients suffering from tuberculosis is fundamentally and primarily a public service for the protection of the health of other people. The treatment, however, of the individual, after he is admitted to the hospital, is a personal matter with that patient and does include, of course, such medical and surgical measures as may be necessary to rehabilitate such patient.

*The Need for Amendments to Present Laws:* It is apparent that there is an urgent need for amendments to the present laws, as well as changes in present practice, to ensure hospitalization for tuberculosis on a public health rather than a welfare basis. Considering the economic status of all but a very small percentage of tuberculosis patients, it is believed that the amount of revenue which can be justly obtained through the payment for hospital care by patients or relatives, would be greater if the Public Health Law were changed, making it permissible rather than obligatory to pay in whole or in part when the patient can afford to do so.

As a matter of actual experience, the yield in dollars in tuberculosis hospitals by direct payment of patients or their relatives is such an insignificant amount that, at least in sections of this State, the cost of making the investigations for all patients admitted, which are made in accordance with present laws, exceeds the amount of revenue which has been obtained from the few patients who were determined as able to pay for hospitalization.

The fact that but a small percentage of families in which tuberculosis is a problem can afford to pay for hospital care is evidenced by national and state surveys, and figures compiled by the Division of Tuberculosis, New York State Department of Health.

According to the survey of the tuberculosis hospitals by the American Medical Association in 1935, only 9 percent of all patients hospitalized in all tuberculosis hospitals in the United States were able to pay for part of their care, and only 6 percent for all of their care.

In county and city tuberculosis hospitals in Upstate New York, the total amount of money received from patients who were able to pay for part or all of their care represents less than 3 percent of the total cost of running these hospitals.

Of the 30 county and city tuberculosis hospitals complete data is available for only 18. Last year \$2,481,613.23 was expended by these 18 hospitals and \$54,909.88 collected from patients, residents of the respective counties, who were able to pay for their care.

This represents 2.2 percent of the total expenditure for the purpose in these hospitals.

*Cost of Tuberculosis:* A recent analysis of 100 consecutive admissions to the Mount Morris Tuberculosis Hospital revealed that over half of these patients were either on relief or had a total annual family income of less than \$1,000, and 32 additional families had an income of between \$1,000 and \$2,000. Nine had a family income of between \$2,000 and \$3,000, and four between \$3,000 and \$4,000, while the additional four could not be clearly classified. Subtracting those patients who were admitted for diagnostic purposes and whose length of stay was only one, two, or three weeks and who could afford to pay for their hospital care for this period, only two patients had a family income sufficient to carry the burden of the cost of hospitalization. This 2 percent parallels the figures previously quoted.

*Possible Need for Financial Grants in Aid to Families of Tuberculosis Patients:* The dire results of further depleting the financial resources of families in which tuberculosis exists is not well known. Insufficient nutrition, more cramped and less sanitary living quarters, and overcrowding all become the natural outcome of depleted family resources and all contribute to the spread of tuberculosis. As a matter of fact, in addition to relieving families of the financial obligation of payment for a patient's care, there seems to be considerable evidence to warrant financial assistance to families in which tuberculosis is a problem. Grants should be given in a manner free from any stigma of indigency. Should the policy of recognizing tuberculosis fundamentally as an economic problem be adopted, as it has been in the eradication of tuberculosis in cattle, but using different methods applicable to the human problem, enormous economic and health benefits would accrue.

A summary of the tuberculosis hospitalization situation in New York State, exclusive of New York City, reveals the following:

1. There appears to be no actual excess in the number of necessary beds to provide for hospitalization of needy cases of tuberculosis.
2. There is a maldistribution of tuberculosis hospital beds which is resulting in economic waste and is preventing hospitalization of many persons suffering from tuberculosis.
3. Confusion in the administration of the Public Health Law, the County Law and the Public Welfare Law is hampering the control of tuberculosis through the application in some counties of a policy requiring indigency for the admission of tuberculosis patients to hospitals as public charges.
4. The large public investment and the current cost of operating these hospitals together with the unequal distribution and inefficient utilization of beds warrants a thorough appraisal of the existing system of operation to determine how future economies may be effected. This study is warranted in order that people from every section of the State will be provided and equal oppor-

tunity for treatment, as well as for protection against the spread of this disease.

Among the possibilities which deserve consideration are: (a) State-wide operation of all tuberculosis hospitals on a regional basis so that vacant beds in one county may be used in meeting the urgent needs in neighboring counties; (b) a combination of State operation of some hospitals and State-aid for others; and (c) State-aid for all local public tuberculosis hospitals.

*Tuberculosis Hospitalization in New York City.*—There exists urgent need for additional hospital beds for the care of tuberculosis patients in New York City. At least 5,000 additional beds are needed to fulfill present requirements according to an estimate of Dr. S. S. Goldwater, Commissioner of Hospitals in New York City. At the present time approximately 5,250 beds are in use in public institutions for the tuberculous. This figure includes beds at the New York City Sanatorium at Otisville and at the State Tuberculosis Hospital at Raybrook.

New York City now has slightly more than one bed for each annual death from tuberculosis in contrast to the ratio of 2.4 beds existing in Upstate New York. As evidence of the present deficit in tuberculosis hospital facilities in New York City, the overcrowding in September, 1939, is presented. The eight tuberculosis hospitals operated by the Hospital Department have a combined bed capacity of 2,811. At the beginning of September there were 3,173 patients hospitalized in these institutions, an excess of 362 over the normal capacity. At the same time 303 patients ready for immediate admission were on the waiting list at the Hospital Admission Bureau.

New York City receives no State aid for the maintenance of its tuberculosis hospitals. The only State assistance is in the form of a small allotment of beds for New York City patients at the Raybrook State Tuberculosis Hospital.

There is a divided public responsibility for the control of tuberculosis in New York City. Prior to 1929 the hospitalization of the tuberculous was under the jurisdiction of the Department of Health. In 1929 hospital facilities were consolidated under the Department of Hospitals. The registering, case finding, and supervision of tuberculosis patients still rests with the Department of Health. Both the Departments of Health and Hospitals operate diagnostic, consultative, therapeutic and follow-up clinics independently of one another.

### Dental Care—With Emphasis on Oral Hygiene in Childhood

The wellnigh universal need for dental care has been brought out through various surveys. Studies in New York City have found over 90 percent of school children with dental disease. Practically all adults are found to have dental disease in some degree.

Attempts have been made to estimate the costs of needed dental services. For children a cost of \$10 per year per child with a



reduction of 50 percent after the second year of dental care is the characteristic estimate. The actual costs, exclusive of orthodontic treatment, at the Murry and Leonie Guggenheim Dental Clinic in New York City, have been slightly higher than these estimates. The relative extent of dental costs for children may be appreciated when it is remembered that the annual cost of elementary school education in the larger cities is slightly over \$100.

For adults in need of dental service the average total cost of rehabilitation at clinic rates was estimated at \$84. To obtain this estimate the needs of a group of patients who presented themselves for care at the Temporary Emergency Relief Administration Dental Clinic in New York City were used as average adult needs and the charges of a self-supporting pay dental clinic in New York City were applied. Other studies of incidence of dental disease in adults indicate that the conditions considered were not exceptional for urban populations.

Dentistry is expensive when compared with other health services. It is, therefore, particularly important to take a preventive approach in this field. This has been the object of governmental efforts which have been directed mainly toward the preschool and school age groups. By maintaining good oral hygiene in childhood the need for extensive dental restorative work in adult life should be materially reduced. Evidence that nutrition and general bodily health play important roles in the prevention of dental disease suggests that dental hygiene should be an integral part of the general health program. It is felt that dental hygiene as part of the school hygiene program can, by instilling good habits and attitudes, aid in preventing adult dental ills.

In New York State Dental Hygiene is included among the health services promoted and supervised by the Department of Education. The responsibility for this school dental program rests with the local boards of education and trustees. There is an increasing tendency to employ dental hygiene teachers who combine educational with service functions.

In the New York State Department of Health, oral hygiene activities are carried on by the Division of Maternity, Infancy and Child Hygiene under the direction of a full-time dentist. During 1939 clinics organized in 101 communities in 14 upstate counties made use of the services of local part-time dentists and dental hygienists. These clinics served 198 infants, 3,217 preschool children and 118 pregnant women in 1939. The establishment of this clinic program is sponsored by the State and the local communities and participates in Federal grants. The program is designed to serve the preschool child and the expectant mother, and education of the public in the importance of childhood dentistry is stressed.

In New York City the Dental Division of the Department of Health is now included in the Bureau of District Health Administration. During 1938 this division operated 135 clinics, the majority in public schools, and 87,141 children made 354,791 visits to these clinics. The growth of this clinic service is shown by

comparison with the 1934 figures when 83 clinics served 51,580 children who made 165,622 visits. The New York City Department of Health dental service is educational, prophylactic and operative. In addition to the Civil Service employees, WPA and ERB assigned professional personnel to the Department for this work.

### Drug Addiction Control

An estimate of the extent of the problem of narcotic addiction in New York State places the number of addicts at about 4,000.<sup>7</sup> It is impossible to obtain exact information, since no reporting of this disease is in force.

Narcotic addiction is now recognized as a disease entity with definite symptoms. It is one of especial interest to the community because of the psychological and social adjustment factors involved. The addicted individual becomes most dangerous to society when he cannot secure his supply of the drug which he needs to prevent violent withdrawal symptoms. Then he may resort to law breaking to obtain it. In California it was estimated by a legislative commission that 80 percent of addicts become criminals.

That the problem is an increasing one is illustrated by a statement from the Bureau of Narcotic Control of the New York State Department of Health. During the month of April, 1940, among commitments to Onondaga Penitentiary there were more addicts arrested and convicted of law violation than during any month in the last ten years. However, not all offenses of drug addicts can be charged to addiction, since factors which lead to criminality also lead to a higher proportion of addiction among criminals than among the general population. The Bureau of Narcotic Control further reports a tendency of magistrates in New York State to suspend sentence in the case of drug addicts convicted of petty crimes. This is no doubt due to the lack of treatment facilities in penal institutions and the recognition that the addict is in need of medical treatment rather than "correction."

Medical treatment of narcotic addicts is hampered by lack of hospital facilities for their care. Ambulatory treatment was tried in New York State in 1919 and discarded. No State hospital facilities for treatment of drug addiction exist except in the State mental hospitals. Both public and private general hospitals are reluctant to admit addicts as they are difficult and undesirable patients. Care in private institutions designed for the purpose, is prohibitively expensive for the majority of addicts. A few counties have made arrangements for short courses of treatment in general hospitals. These are usually for only long enough to withdraw the drug and seldom allow time for psychiatric rehabilitation.

A report of the sub-committee of the Committee on Public Health Relations of the New York Academy of Medicine has sum-

<sup>7</sup> Director, Bureau of Narcotic Control, New York State Department of Health, May, 1940.

marized public facilities for the treatment of narcotic addicts and alcoholics as follows:

“With the exception of two institutions operated by the United States Public Health Service, one at Lexington, Kentucky, and the other at Fort Worth, Texas (which are generally known as ‘narcotic farms’), there is no public provision for New York residents for the treatment of drug addiction except in penal and correctional institutions. For those addicts in moderate circumstances who desire a cure but who cannot afford treatment at \$8.00 or \$10.00 a day in private institutions and who cannot gain admission to the federal farms (which are populated with addicts from federal prisons as well as those who seek treatment voluntarily), the only available facilities are prisons to which they can gain admission by applying for a voluntary commitment before a magistrate. The treatment offered in the correctional institutions can in no way be considered as adequate. At Riker’s Island it is of a 100 days’ duration and in the House of Detention for Women it is limited to 42 days. This allows little time for any treatment beyond the withdrawal of the drug and a short period of subsequent physical building up; no opportunity is available for the investigation and psychiatric treatment of those mental and emotional factors which are the primary cause of the addiction and without whose correction any permanent cure is impossible.

“The problem of drug addiction in these institutions is by no means a small one. In 1939, 2,000 drug addicts were admitted to Riker’s Island, either by self-commitment proceedings or because of a sentence. During the same year 800 addicts were admitted to the Women’s Prison, about one-third of whom were self-committed. A census taken at Riker’s Island on a single day last March revealed that of the 1,159 inmates, 557 or 48 percent were drug addicts. One hundred of these inmates were self-committers and 60 were sentenced on the grounds of possession of drugs. A study of addicts who received penitentiary sentences in 1934 reveals that only 14 out of 151 addicts were serving their first sentence and that 96 had had 5 or more previous sentences. According to the Deputy Commissioner of Correction ‘. . . it is evident that drug addicts form one of the larger, if not the largest group of recidivists in our penitentiary population.’

“From its preliminary review of this problem, the Subcommittee is convinced that, while some provision should be made for the complete cure of those addicts for whom the chances of rehabilitation appear to be good, it would be financially impossible and of problematic worth for the community to provide facilities for the long-term care of all addicts. Privately endowed institutions which could select patients on the basis of possible social reclamation would be preferable to state institutions which would have to open their doors to the rank and file of applicants.

“The experience of the authorities at the Lexington narcotic farm indicates that many self-committed addicts leave the institution before the treatment is completed. A judicial interpreta-



tion has declared that self-committers cannot be detained against their will. The Subcommittee has been informed that long-term commitments to privately endowed, experimental institutions could be more easily arranged than lengthy commitments to government institutions.

"Furthermore, in the opinion of the Subcommittee, the alcoholic, as well as the drug addict, should be given an opportunity for cure, and because of the similarity of the two problems, the two types of patients might well be cared for in the same institution. It has been suggested that inclusion of inebriates might stimulate financial support for such a project.

"The Subcommittee therefore recommends that consideration be given to the possibility of establishing a privately financed institution to treat alcoholics and drug addicts for whom there are indications of possible reclamation. The institution should be devoted primarily to research in causes and treatment of alcoholism and drug addiction. Besides hospital accommodations for research, it should also have facilities for training the inmates in various skills and occupations, and should have an employment service and a follow-up service. Such an experimental research institution may eventually lead the way to a better understanding of how to deal with this problem on a more comprehensive scale through public agencies."

The Legislative Health Commission recognizes that the control of narcotic addictions, is one of the many health problems involved in the formulation of a State health plan.

### **Physical and Social Rehabilitation for Handicapped Children**

The New York State Department of Health, following the poliomyelitis epidemic of 1916, began a program of rehabilitation of handicapped children. The service grew and in 1926 the State Legislature passed amendments to the Children's Court Act and to the State Education Law establishing a definite program to provide this rehabilitation.

The program for rehabilitation of crippled children is the joint responsibility of the local community, the Children's Court and the State Departments of Health and Education. No public funds can be expended for a child without an order of the Children's Court judge. If the State Departments of Health and Education approve the service called for, State aid up to one-half the amount is granted to the local community from a fund in the budget of the State Department of Education. Since medical service for crippled children is expensive and long drawn out the average family is unable to afford the cost. Neither is the average locality able to afford competent and adequate service and care for its crippled children.

The demands on the State program of rehabilitation of crippled children increased, and, upon the recommendation of the 1930 New York State Health Commission, this work was established

as a Division of Orthopedics in the State Department of Health.<sup>8</sup> The Division is headed by a physician director and has a central office staff. For administrative purposes the State is divided into five districts, each of which is headed by a part-time District State Orthopedic Surgeon.

The Division of Orthopedics of the State Department of Health has as its chief activity the diagnosis, treatment, supervision of care and follow-up procedures of all orthopedic cases reported to it. Carrying out these activities during the year 1939, a total of 360 clinic sessions were held with an attendance of 12,245 patients, of which 2,917 were new patients.

Thirty-two State orthopedic nurses, including a supervisor and an assistant supervisor of orthopedic nurses, have been doing field work during the past calendar year. A total of 32,513 visits to and in behalf of orthopedic patients were made by the orthopedic nurses during the year 1939. This service was rendered to a total of 8,381 patients, an average of approximately four visits per patient.

The total amount approved for State aid by court order for the calendar year 1939 was \$916,688.91, an increase of approximately \$140,000 over the previous year. A large proportion of the increase was for care given in the City of New York, since several institutions in New York City not previously approved for State aid reorganized their work to conform with State regulations. The total number of court orders calling for this expenditure was 2,922, for a total of 2,301 patients, 1,353 of whom had not received State aid prior to 1939.

Under the provisions of the Social Security Act, the Federal Government allocated \$147,056.50 to New York State for crippled children's work during the fiscal year 1939-1940. Plans approved by the Federal Government called for an expenditure of \$147,818. The additional amount needed was covered by a portion of the unexpended balance as of July 1, 1939, which was \$141,736.45.

The Division of Orthopedics cooperates with the State tuberculosis hospitals by rendering an active orthopedic service. This includes consultation and medical service for any bone and joint condition hospitalized in these institutions. The number of patients requiring this care is increasing. At the present time about one-third of the time of one physician of the Central Office staff is devoted to this service.

Several requests for orthopedic service have been received in the past from the State Department of Correction. In 1939 an effort was made to comply with these requests in several institutions under the jurisdiction of that Department.

The New York State Reconstruction Home for the rehabilitation of handicapped children is maintained by the State at West Haverstraw. This hospital is under the jurisdiction of the State department of Health and has a capacity of 350 beds.

<sup>8</sup> Chapter 481, Laws of 1931.

The Division of Orthopedics makes an effort to inform the general public concerning the aims of its program and the services available in New York State for the rehabilitation of crippled children. The program stresses the responsibility of the local community toward the rehabilitation of handicapped children and presents the State Department of Health as an agency to assist the family, physician and local community.

### Extension of Approved Laboratory Facilities and Services

It is of public health concern that the identification of disease be made promptly. The service rendered to physicians by laboratories in the discovery, identification, prevention and therapy of disease is indispensable to the modern practice of medicine. The application of biology to the scientific control of disease has broadened the scope of service rendered by the laboratory to the physician, the patient and the general public.

The Commission recognized the importance of laboratory services to the health of the public by including in its Preliminary Report to the Legislature the recommendation<sup>9</sup> for the improvement and extension of services. The realization of this recommendation includes:

1. Further development of diagnostic service by continuing grants of State aid to county and city laboratories and by encouraging expansion of such approved systems or their establishment where such services cannot be provided by arrangements with existing laboratories, so that facilities including the advice and counsel of competent experts in pathology and bacteriology through personal consultation locally, are readily available to every physician in the State.

2. Further provision as indicated of diagnostic, prophylactic and therapeutic preparations by the State Department of Health, so that the general practitioner may have these essential aids within reach for his patients in all income brackets.

3. Continuation and extension of research and related field studies by State and local laboratories with the aim of improving and developing technical methods and thus of providing more efficient or new aids to the practicing physician particularly in such baffling but urgent problems as the virus diseases and those of indeterminate nature.

*Present Laboratory Services.*—In New York State 424 hospitals maintain clinical laboratories and 96 hospitals send out all of their laboratory diagnostic work. There are at present in the State exclusive of New York City approximately 130 local diagnostic laboratories approved by the State Department of Health and located in 45 of the 57 counties included. With important exceptions all sections of the State are within reach of one or more of

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<sup>9</sup> Preliminary Recommendation 6. Preliminary Report Transmitted May 15, 1939 (Legislative Document 1939), No. 97, p. 4.



these laboratories. The majority are located in hospitals. Since 1937 laboratories applying for approval must as a prerequisite for consideration be directed by a physician thoroughly trained in pathology as well as in other diagnostic laboratory procedures and qualified to act as a consultant. These laboratories must be equipped to perform all of the principal tests which are considered essential to the efficient practice of medicine. State aid is granted to most of the approved county and city laboratories to broaden their facilities and to insure free service for patients unable to pay.

The Progress and development of local laboratory service in the State are shown by the number of examinations made in the approved laboratories, namely 3,956,092 in 1938 contrasted with 102,000 in 1915. During the same 23 years the examinations in the Division of Laboratories and Research of the State Department of Health increased from 48,000 to 651,903.

*Provision of Prophylactic, Therapeutic and Diagnostic Preparations.*—Antitoxins, sera and vaccines are prepared and distributed to physicians free of charge by the Division of Laboratories and Research of the State Department of Health through 200 district laboratory supply stations established in accordance with the Public Health Law and located throughout the State exclusive of New York City. Stations in areas not provided with approved local diagnostic facilities also maintain outfits for the submission by physicians of specimens to the Division of Laboratories and Research. A few outfits are kept in all stations so that specimens can be submitted to the Division for confirmatory examination. Drugs for the treatment of syphilis have since 1936 been furnished through supply stations irrespective of the patient's financial status. Several new products, in particular anti-pneumococcus sera of additional types, have more recently been prepared and made available, and this policy will be continued as indicated. Diagnostic sera and reagents, prepared and carefully standardized at the Division, are furnished to approved laboratories in order to promote accuracy and uniformity in diagnostic procedures.

*State Aid for Laboratory Service.*—Since 1923 when the Public Health Law was amended to provide State aid for the extension of local laboratory service particularly in the rural areas, the number of counties and cities that have taken advantage of this opportunity has continued to increase. While State aid is given primarily for the establishment of new laboratories, it has also been of assistance in developing existing service. Great care is exercised in its administration to insure advancement of the work and not to relieve the community of obligations already assumed. State aid is granted only to help defray legitimate expenses actually incurred. Counties or cities receiving this assistance are expected to provide themselves with an approved diagnostic laboratory service that will care for their principal needs. The facilities thus provided have been so much appreciated that in no instance have the local governments withdrawn their appropriations for this purpose.

It is the intent of the law that the funds provided will permit necessary laboratory work being done at a moderate charge or free. Thus, laboratories maintained through State aid are expected to do work free of charge in case the physician indicates that it would be a hardship for a particular patient to pay for the laboratory service. Not only examinations for evidence of communicable disease but also all types of essential diagnostic laboratory examinations are included.

The State aid law also provides for the establishment of qualifications for directors and bacteriologists in charge of laboratories receiving State aid. (These qualifications have since been extended to apply also to persons in charge of all approved laboratories.) Thus, the standards of local laboratory work throughout the State have been advanced and it has been possible to secure directors who are eminently fitted for their duties. As a result, the counsel of experts in laboratory work has been made available to physicians in these districts.

Nearly all of the laboratories have been established in hospitals, where they are particularly accessible. Physicians who come to the hospital are afforded an opportunity to discuss puzzling cases with the director or to arrange for him to see patients with them when necessary. It is desirable when laboratory facilities are made available in a county for all hospitals to participate in the service, in order to provide physicians with this most essential aid in diagnosis.

Six cities and 19 counties receive State aid for maintaining laboratories. Six counties receive State aid towards the service rendered under contract. A total of \$161,579.08 was granted in 1938-40.

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## APPENDIX

(See detailed List of Appendices on page 116)

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### Appendix A

#### STUDY OF MEDICAL CARE FOR NOVEMBER 1939

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##### Purpose and Scope

The New York State Temporary Legislative Commission to Formulate a Long Range State Health Program desires to evaluate, for a given month, the problems and methods in administering medical and hospital care to the medically indigent of New York State and to determine:

*I. Medical and Hospital Care Authorized During November 1939 (Form MC-1)*

A. Number of Authorizations and Persons Authorized to Receive Medical and Hospital Care.

1. Authorizations and persons classified by relief status and type of care.
2. Authorizations and persons with relief status, classified by type of relief and type of care.

B. Number of Different Persons Authorized to Receive Medical and Hospital Care.

1. Number of different persons with relief status, classified by type of care and age.
2. Number of different persons with non-relief status, classified by type of care and age.

*II. Volume of Applications for Medical or Hospital Care for Non-relief Cases Only, November 1939 (Form MC-2)*

*III. Factors Involved in the Disposition of Applications for Medical or Hospital Care for Non-relief Cases Only (Form MC-2a)*

##### Procedure

*I. Form MC-1—Medical and Hospital Care Authorized During November 1939*

This report is to be submitted to the Legislative Health Commission by each of the County and City Commissioners of Welfare.

The County Commissioners will obtain similar reports (omitting Part II of Section A—Authorizations and Persons with Relief Status, Classified by Type of Relief and Type of Care) from each town under jurisdiction of the county. A supply of Form MC-1 is being sent to each County Commissioner who will distribute a set of these forms to each town.

At the expiration of the period of study, each town will submit its report on Form MC-1 to the County Commissioner who will utilize the reports from the towns in compiling the report for the entire county.



*II. Form MC-2—Summary of Applications for Medical or Hospital Care for Non-Relief Cases Only, November 1939*

This report is to be submitted by the County and City Commissioners of Welfare to the Legislative Health Commission. The same procedure is to be followed for the distribution of these forms to the towns within each county, and for compiling the report for a given county, as described for Form MC-1.

Duplicate sets of Forms MC-1 and MC-2 are being sent, in order that the County and City Commissioners may retain copies for their own files.

*III. Form MC-2a—Application for Medical or Hospital Care for Non-Relief Cases Only*

Each County and City Commissioner is being sent a limited supply of this form which is to be filled out for each application pending on November 1, 1939, and for each application received during the month of November 1939. The County Commissioners will supply each Town Welfare Officer with the required number of forms.

When the reports on Form MC-2a have been filled out by the towns, they are to be returned to the County Commissioner of Welfare who will forward them to the Legislative Health Commission, together with the reports on Form MC-2a filled out by the County office.

An additional supply of Form MC-2a will be sent to the County and City Commissioners upon request.

**Submission of Data**

The data gathered through the cooperative effort of County, City and Town welfare officials are to be the basis for the preparation of one of the sections of the report of the Legislative Health Commission, to be submitted to the New York State Legislature not later than March 15, 1940.

County and City Commissioners are, therefore, earnestly urged to submit the reports requested on or before December 15, 1939.

**INSTRUCTIONS FOR PREPARATION OF FORM MC-1,  
MEDICAL AND HOSPITAL CARE AUTHORIZED DURING  
NOVEMBER, 1939**

**SECTION A**

*Part I—Authorizations and Persons Classified by Relief Status and Type of Care*

Part I of Section A is concerned with the number of authorizations issued and the number of persons authorized during November, 1939 to receive medical and hospital care. These data are to be shown separately for persons who, at time of application for medical care, were recipients of public relief (home relief, including veteran relief; old age assistance; aid to dependent children; assistance to the blind; institutional or foster home care; medical care, including hospital or clinic care; or any other form of public relief) and for persons who were not recipients of public relief.

*Column 1* represents the total number of authorizations for all persons and is equal to the sum of *columns 3 and 5*.

*Column 2* represents the total number of persons (relief and non-relief) authorized to receive medical and hospital care and is equal to the sum of *columns 4 and 6*.

The number of authorizations and the number of persons are to be distributed according to type of care authorized as indicated in items II, A-G, and III.

*Item I* is equal to the sum of *items II and III* and *item II* is equal to the sum of *items A-G*.

*Part II—Authorizations and Persons with Relief Status, Classified by Type of Relief and Type of Care (not to be filled out by Towns)*

Part II of Section A is concerned with the authorization of medical and hospital care for relief recipients only. The number of authorizations and the number of persons authorized during November, 1939, to receive medical and hospital care are to be reported according to the type of relief received. These data are to be further classified by type of medical care authorized.

It should be noted that the sum of *columns 1, 3, 5, 7, 9 and 11* should be the same as *column 3* of Section A, Part I. It will also be noted that the sum of *columns 2, 4, 6, 8, 10 and 12* should be the same as *column 4* of Section A, Part I.

*Item I* is equal to the sum of *items II and III* and *item II* is equal to the sum of *items A-G*.

#### SECTION B

*Number of Different Persons Authorized During November, 1939, to Receive Medical and Hospital Care*

This section, which relates to the number of different persons authorized for medical or hospital care, is divided into two parts as follows:

*Part I*—Refers to the number of different persons who were receiving public relief at time of application for medical care, and have been authorized during the month of November, 1939, to receive medical or hospital care.

*Part II*—Refers to the number of different persons who were not receiving public relief at time of application for medical care, and have been authorized during the month of November, 1939, to receive medical or hospital care.

In both Parts I and II, the data are to be reported separately for medical and hospital care and are to be classified by sex and age.

If two or more authorizations for medical or hospital care have been issued for a given individual during the month, that individual is to be counted only once in this section.

*Column 1* is equal to the sum of *columns 2 and 3* and is also the sum of *columns 4 and 7*. *Column 2* is equal to the sum of *columns 5 and 8*. *Column 3* is equal to the sum of *columns 6 and 9*.

*Column 4* is equal to the sum of *columns 5 and 6* and *column 7* is equal to the sum of *columns 8 and 9*.

*Item I* is equal to the sum of *items a-1*.

Form MC-1

**MEDICAL AND HOSPITAL CARE AUTHORIZED DURING  
NOVEMBER 1939**

Name of County.....

Name of City..... Town.....

**SECTION A**

**NUMBER OF AUTHORIZATIONS AND PERSONS AUTHORIZED DURING  
NOVEMBER 1939 TO RECEIVE MEDICAL AND HOSPITAL CARE**

*Part I — Authorizations and Persons Classified by Relief Status and Type of Care*

TYPE OF CARE	TOTAL		RELIEF STATUS		NON-RELIEF STATUS	
	NUMBER OF		NUMBER OF		NUMBER OF	
	Authori- zations (1)	Persons (2)	Authori- zations (3)	Persons (4)	Authori- zations (5)	Persons (6)
I. Total						
II. Medical Care						
A. Physician						
1. General practitioner						
a. Office						
b. Home						
2. Specialist						
a. Office						
b. Home						
3. Obstetrical care						
a. Home						
b. Hospital						
4. Other special services by physician						
B. Dental care						
1. Extractions						
2. Other						
C. Nursing care						
1. Registered nurse						
2. Nurse-housekeeper						
D. Drugs						
E. Appliances						
F. Clinic care						
G. Other						
III. Hospital Care (other than obstet- rical care)						











Form MC-1

Sheet 4

Name of County.....

Name of City..... Town.....

## SECTION B (Continued)

*Part II — Number of Different Persons with Non-Relief Status, Classified by Type of Care and Age*

AGE	TOTAL			MEDICAL CARE			HOSPITAL CARE		
	Total	Male	Female	Total	Male	Female	Total	Male	Female
	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)
I. Total									
a. Under 1 year									
b. 1 year and under 2									
c. 2 years and under 5									
d. 5 years and under 10									
e. 10 years and under 15									
f. 15 years and under 20									
g. 20 years and under 25									
h. 25 years and under 35									
i. 35 years and under 45									
j. 45 years and under 55									
k. 55 years and under 65									
l. 65 years and over									

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(Signature)-----  
(Title)

Appendix B

SUMMARY OF APPLICATIONS FOR MEDICAL OR HOSPITAL CARE,  
NOVEMBER 1939  
(For Non-Relief Cases Only)

Name of County.....

Name of City..... Town.....

- 1. Pending on November 1, 1939.....
- 2. Received during month.....
- 3. Total during month (sum of items 1 and 2).....
- 4. Disposed of during month (sum of items 4a-4c).....
  - a. Approved.....
  - b. Denied.....
  - c. Disposed of for other reasons  
(withdrawals, deaths, etc.).....
- 5. Pending on November 30, 1939 (item 3 minus item 4).....

NOTE.— The total number of reports submitted on Form MC-2a should agree with the number recorded in item 3.

.....  
(Signature)

.....  
(Title)

## Appendix C

### INSTRUCTIONS FOR PREPARATION OF FORM MC-2a, APPLICATION FOR MEDICAL OR HOSPITAL CARE

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Form MC-2a is to be filled out for each application pending on November 1, 1939, and for each application received during the month of November 1939, for medical or hospital care, where the applicant is not receiving public relief, such as home relief (including veteran relief), old age assistance, aid to dependent children, assistance to the blind, institutional or foster home care, medical care (including hospital or clinic care), or any other form of public relief, with the exception of WPA.

*Item 1*—Enter the number assigned to the case if the application was approved during the month. If the application was denied during the month or is still pending at the end of the month, and, therefore, no case number has been assigned, enter the application number.

*Item 3*—Enter the age (as of last birthday) of the applicant at time of application.

*Item 5*—Report separately the number of related members (including applicant) and unrelated members in the household. For the purpose of this schedule, a household is defined as a family group or a group of related and unrelated persons living together, who share a common income which may be earned by one member of the group or which may result from the pooling of income of several members. Unmarried children, and other relatives, if they are considered as a part of the family group and economic unit, and not as a separate family unit, should be considered as members of the household even though they pay a definite amount for board and room instead of sharing a common family income. For the purpose of this form, boarders and lodgers who are not related to members of the household and who pay a definite amount for services received, should not be considered as members of the household.

*Item 6e*—Specify name of agency or relationship of individual to applicant.

*Item 7a*—Enter the date on which the present application was accepted for investigation. Disregard any previous application date whether accepted or rejected.

*Item 7b*—Enter the date of authorization for medical or hospital care, regardless of the date on which such care was received.

*Item 7d*—Check if final action has not been taken and the application is still awaiting decision at the end of the month.

*Item 8a*—Check if applicant, prior to this time, was not in receipt of public relief such as home relief (including veteran relief), old age assistance, aid to dependent children, assistance to the blind, institutional or foster home care, medical care (including hospital or clinic care) or any other form of public relief.

*Item 8b*—Check if applicant received some form of public relief earlier in 1939 or prior to 1939. Check items 8b(1) and 8b(2) if relief was received during both periods specified.

*Item 8c(1)*—Check if applicant was working on a WPA project at the time of this application.

*Item 8c(2)*—Check if applicant was not working on a WPA project at the time of this application but was so employed earlier in 1939 or prior to 1939. Check both if employed during each of the periods specified.



*Item 9a*—Include also regular cash income received from legally responsible relatives.

If there has been no income during the period of present illness or prior to the onset of illness, enter "none."

*Item 9b*—All resources, exclusive of the regular monthly cash income of the family, are to be considered here.

- (2)—Indicate the face value of insurance holdings.
- (3)—Indicate the assessed valuation of real estate owned by family.
- (4)—Enter the estimated market value.
- (5)—Include such assets as benefits, investments and personal property.

*Item 11b*—If diagnosis, indicate whether made by a private physician, city physician, or a physician in a hospital or clinic.

*Items 12 and 13*—Each application should cover as many types of medical care as are requested or authorized on a given date. For example, a general practitioner may prescribe drugs as part of the treatment plan. When this is done, both items (a)1 and (d) should be checked. An ophthalmologist may do an eye examination and prescribe glasses. If the welfare department pays for the glasses, as well as for the eye examination, both items (a)2 and (e) should be checked.

(a)2—Such services may include the following: eye examination, examination by a specialist in orthopedics, consultation by a specialist in cases of severe illness and any other professional services in the home or office by a physician whose practice is limited in whole or in part to one particular branch of medicine such as surgery, obstetrics, etc.

(a)3—Include here physician's services at confinement in the hospital or in the home. Do not include requests or authorizations for prenatal care early in pregnancy but check this under item (a)1. If request or authorization is for an all-inclusive service to cover prenatal care, delivery and postnatal care, indicate this in item (a)4 as follows: prenatal, delivery, and postnatal care. If request or authorization is for postnatal care only, check item (a)1.

(a)4—Include here those items of medical care given by physicians in the patient's home or in the physician's office and which are not included in items (a)1, (a)2 and (a)3. Such items may include the following: radium, diagnostic x-ray, treatment x-ray, laboratory services in the office of a physician, electrocardiogram, basal metabolism, reduction of fracture in patient's home or physician's office, minor surgery in patient's home or physician's office, etc.

(b)1—Include simple extractions and dental surgery.

(b)2—Include here all dental work, with the exception of extractions, such as: dentures, denture repairs, fillings, dental x-rays, prophylaxis, treatment of pyorrhea or Vincent's angina, etc.

(c)1—Check here for the following: services of registered nurse on duty in the hospital or home on a per diem basis, services of a registered nurse in the home on a per visit basis, services of a registered nurse assisting physician at delivery.

(c)2—Check here for services by those who are not registered professional nurses, but whose duties include some nursing services as well as certain household responsibilities.

(d)—Check here for all drug items prescribed or dispensed by a physician including sickroom supplies such as bedpans, icebags, gauze, etc.

(e)—Check here for eyeglasses, braces, artificial arms or legs, trusses, special shoes, special corsets or abdominal supports, wheelchairs, crutches, etc.

(f)—Check for hospital care. If fees are paid to physicians or surgeons in addition to the amount paid to the hospital, indicate in item (a)4 that such fees are authorized in addition to the hospital costs.

(g)—Include only such clinic services as are to be paid for by the local welfare department. Check if x-ray diagnosis, x-ray treatment, physiotherapy, or other special diagnostic treatment or services are to be provided in the clinic and are to be paid for by the welfare department.

(h)—Include admissions to county home infirmaries, admissions to nursing or boarding homes for chronically ill, payment to private laboratories, transportation to and from Cancer Institute, Buffalo, transportation to other communities for special medical services, special diets, payments to blood donors, etc.

*Item 14b*—Indicate whether or not a plan has been worked out with the family whereby the latter is to repay the local agency any part of the cost of the medical care now authorized.

*Item 14c*—If such agreement has been made, indicate whether all or only part of the expenditures are to be repaid. Also enter the amount to be paid each month and the number of months payments are to be made.

*Item 15*—If this application for medical care was denied, check one of the reasons indicated in item 15a, b, c or d, which is applicable in this case.

(a)—If the medical care requested by applicant is available at a public or private medical agency, such as a hospital or clinic, give the name of agency.

(b)—On basis of applicant's own statement or agency's clearance with physician.

Form MC-2a

Sheet 1

## CONFIDENTIAL

APPLICATION FOR MEDICAL OR HOSPITAL CARE  
(For Non-Relief Cases Only)

Name of County.....

Name of City..... Town.....

1. Case or application number.....
2. Name of applicant.....
3. Age.....
4. Sex (check): (a) Male..... (b) Female.....
5. Number in household: (a) Related..... (b) Unrelated.....
6. Application made by (check): (a) Patient..... (b) Member of household.....  
(c) Physician..... (d) Hospital..... (e) Other (specify).....
7. (a) Date of this application..... 1939  
(Month) (Day)  
(b) Approved..... 1939 (c) Denied..... 1939  
(Month) (Day) (Month) (Day)  
(d) Pending on November 30, 1939 (check).....
8. Relief status (check):  
(a) Not previously on relief.....  
(b) Previously on relief: (1) During 1939..... (2) Prior to 1939.....  
(c) On WPA: (1) At time of application..... Prior to 1939.....  
(2) Not at time of application but earlier in 1939.....
9. (a) Estimated average monthly cash income of family:  
(1) During illness..... (2) During year prior to onset of illness.....  
(b) Assets on hand:  
(1) Bank account \$..... (2) Insurance \$..... (3) Real estate \$.....  
(4) Farm and garden products on hand \$.....  
(5) Other (specify)..... \$.....
10. (a) Monthly budget of family used in this case to determine eligibility to pay  
for medical care \$.....  
(b) Is this higher than a regular relief budget for this case? (check):  
Yes..... No.....  
(c) If higher, state regular relief budget \$.....
11. (a) Complaint or diagnosis.....  
.....  
(b) If diagnosis, by whom made.....



Form MC-2a

Sheet 2

# APPLICATION FOR MEDICAL OR HOSPITAL CARE (For Non-Relief Cases Only)

Name of County.....

Name of City..... Town.....

## 12. Medical care requested (check):

- (a) Physician: (1) General practitioner: Office..... Home.....  
 (2) Specialist: Office..... Home.....  
 (3) Obstetrical care: Home..... Hospital.....  
 (4) Other special services by physician (specify).....  
 (b) Dental care: (1) Extractions..... (2) Other.....  
 (c) Nursing care: (1) Registered nurse..... (2) Nurse-housekeeper.....  
 (d) Drugs..... (e) Appliances..... (f) Hospital  
 care (Other than obstetrical care).....  
 (g) Clinic care..... (h) Other medical care (specify).....

## 13. Medical care authorized (check):

- (a) Physician: (1) General practitioner: Office..... Home.....  
 (2) Specialist: Office..... Home.....  
 (3) Obstetrical care: Home..... Hospital.....  
 (4) Other special services by physician (specify).....  
 (b) Dental care: (1) Extractions..... (2) Other.....  
 (c) Nursing care: (1) Registered nurse..... (2) Nurse-housekeeper.....  
 (d) Drugs..... (e) Appliances..... (f) Hospital  
 care (other than obstetrical care).....  
 (g) Clinic care..... (h) Other medical care (specify).....

## 14. If medical care is authorized:

- (a) Has family, prior to this application, paid for medical or hospital care in  
 connection with this illness? (check): Yes..... No.....  
 (b) Is family to repay cost of medical care now authorized? (check): Yes..... No.....  
 (c) If yes, family to repay (check): All..... Part..... months;  
 Amount per month \$..... for..... months.

## 15. Medical care refused (check one):

- (a) Care available at a public or private medical agency (name of agency).....  
 (1) Was applicant referred to this agency? (check): Yes..... No.....  
 (b) Private physician will treat (check): Free..... On credit.....  
 (c) Family considered able to pay for own medical care.....  
 (1) Estimate of cost of required medical care \$.....  
 (2) Method by which family can pay (check):  
 Through own resources..... Through assistance of legally  
 responsible relatives outside of household.....  
 Through other means..... (explain).....  
 (d) Medical care not justified at public expense..... (explain).....

(Signature of person responsible for considera-  
tion of application)

(Title)

## Appendix D

### TO BE USED FOR FIRST ADMISSIONS ONLY

Record of inmate.....Public home

To the State Department of Social Welfare: Pursuant to the provisions of section 36 of the Public Welfare Law, the following information from the record of an inmate received in this Home is submitted:

Name.....

Date of admission.....Record number.....

Last residence.....

Age.....Sex.....Color.....Religion.....

Birthplace: { If born abroad, give name of country.....

{ If born in United States, name the state.....

How long in U. S.?.....In N. Y. State?.....Is inmate a citizen of U. S.?.....

How long in your public welfare district?.....

Civil status (Check ✓): Single.....Married.....

Widowed.....Separated.....Divorced.....

Education: Reads.....Writes.....Only.

Number of years in common or grammar school.....

in high school.....in college.....

Occupation.....

Birthplace of father.....Of mother.....

(If born abroad, give name of country; if born in United States, name the state) (Over)

Record of Inmate.....Public home—CONCLUDED

Has physical examination been made and recorded as required by section 94 of the Public Welfare Law?.....

A. Indicate herein defects, diseases and mental condition as found by physician:.....

B. Appraisal of ability to work:.....

1. Is able to work at last regular occupation:.....

Fully....., Partially....., Not at all.....

2. Would be able to do less laborious work than last regular occupation:.....

Fully....., Partially....., Not at all.....

C. Person is admitted for (Check ☒):.....

1. Prolonged residence because of age or chronic disability.....

2. Temporary medical care or nursing.....

3. Temporary shelter pending finding employment.....

Previous care\* of inmate:.....

Name of Institution or Agency	Address	DATES	
		From	To
.....	.....	.....	.....
.....	.....	.....	.....
.....	.....	.....	.....
.....	.....	.....	.....
.....	.....	.....	.....
.....	.....	.....	.....

\* Include previous care in public homes, hospitals for mental diseases, hospitals for feeble-minded, correctional institutions, relief agencies, etc. All public and private institutions and agencies should be indicated.

.....  
Signature and title of reporting official



## Appendix E

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### NAME OF PUBLIC WELFARE DISTRICT

#### General Information:

1. Medical care plans:
  - a. O.A.A.
  - b. H.R. in County DPW and Towns
  - c. A.B.
  - d. S.C.
2. Case load in each category
3. Forms used in medical care plans (get 10 copies)  
(Include any systems)
4. Studies, cost, analysis, etc.
5. List of all personnel by name and title in any way involved in carrying out medical care plan procedures
6. Staff:
  - Administrative
  - Social Service
  - Accounting
  - Stenographic
  - Clerical

(Exact titles as they will be used in final write up)
7. Is there a physician's roster? Kept up to date? How? By whom?
8. How many Medical Manuals are there in each office?

#### II. Request for Physician's Services:

- a. How made:
  1. Telephone by patient or member of family
  2. Direct application by patient or member of family, (Welfare Department)
  3. Direct application to physician who later notifies Welfare Department
  4. Direct application to Welfare Department by another agency, friends, proprietors of boarding or nursing homes, etc.
  5. Direct application to investigator in the field
  6. P.H.N. or H.O.
- b. By whom received in Welfare Department:
  1. Intake Worker
  2. Investigator
  3. Medical Worker
  4. Telephone Operator
  5. Case Supervisor
  6. Other staff members (designate)
- c. (a) Recording of request:
  1. By whom done (give title) same as b
  2. To what other staff members are such records sent
  3. Case history notations, if any, at this point

(b) Forms (use of) list system of recording calls or requests
- d. Decision as to acceptance or rejection of request
  1. By whom made
  2. By whom explained to patient
  3. If rejected what advice is given

- e. Authorization to physician:
  - 1. By whom made (give title)
  - 2. How made (Interim between PA-16A and 277—does someone notify M.D. or patient of delay):
    - a. Telephone
    - b. Verbally during conferences with physicians
    - c. Written order (277)
  - 3. Recording:
    - a. Case history
    - b. Card index system
    - c. Notebook
    - d. Any other plan (specify)
- f. Drugs (include if M.D. dispenses drugs or any other way than M.D.)  
List of drug stores and how they are accessible to patients. (Do they offer delivery service.) Run through cash grocery orders for vouchers in towns for drug or medical supplies on back of food orders. Are drugs left in grant? Have there been heavy deductions? Bulk purchase of drugs? Controls
- g. Extension of physician's services:
  - 1. Beyond two weeks' period (notation whether or not in an extension):
    - a. Who requests extension:
      - 1. Patient
      - 2. Physician
    - b. Who approves extension
    - c. Who authorizes extension:
      - 1. By whom made
      - 2. How made:
        - a. Telephone
        - b. Verbally during conference with physician
        - c. Written order (277)
      - 3. Recording
  - 2. Beyond ten weeks' period:
    - a. Who requests extension:
      - 1. Patient
      - 2. Physician
    - b. Who approves extension
    - c. Who authorizes extension:
      - 1. By whom made
      - 2. How made:
        - a. Telephone
        - b. Verbally during conference with physician
        - c. Written order (277)
      - 3. Recording
    - d. Who assumes responsibility for securing prior approval for chronic care:
      - 1. Title:
        - Accounting Division
        - Social Service Division
      - 2. What procedure for sending Form 4957 to physician and making sure of return with each item properly filled in
      - 3. If procedure carried out by Social Service (supervisor or investigator) list each step:
        - a. Interview with physician  
(Telephone or visit to office)
        - b. Interview with patient
        - c. Recording
        - d. Follow up, if any
  - 3. Outline each detail of system  
(If local's procedure on advice of state worker give name and title)

- h. Securing prior approval from:
  - Senior Medical Social Worker
  - Area Office:
    1. Procedures for sending Forms 4957 to Area Office
    2. Procedures for holding and filing Approved Forms 4957 pending preparation and submission of claim of reimbursement
    3. Procedure for reconsideration of medical care plan for those patients not approved for continued chronic care
    4. Procedures for securing additional medical information necessary to decision re: approval
- i. Submission of bill to physician:
  1. At what intervals
  2. Against what records are individual physician's bills checked:
    - a. Title and number of personnel involved
    - b. Describe each process

#### *Drugs*

1. General policy including any agreements entered into with pharmacists
2. What is basis of selection of drug store:
  - a. Patient's choice
  - b. Welfare Department assignment
  - c. Physician's choice
3. Have physicians been instructed to prescribe U.S.P. or N.F. drugs? (If in writing, get copy)
4. Have pharmacists been informed that Welfare Department will pay only for U.S.P. or N.F. drugs? (If in writing, get copy)
  - a. If such instructions have been given, what procedures are followed for securing payment on drugs other than U.S.P. or N.F.
5. What is department's policy in regard to proprietary drugs:
  - a. Commonly used "patent medicines" such as Sloan's Liniment, Vick's Vapo Rub, etc. (list those used)
  - b. New and general accepted drugs such as liver extracts, glandular preparations, etc.
6. Does Welfare Department print its own prescription blanks? If so, secure copies
7. When physician issues prescriptions, are relief recipients required to get authorization from Welfare Department? If so, describe each step of procedure
 

If no authorization required for each prescription, describe procedure Above may include telephone authorization to druggist, submission of bills daily, weekly or monthly, etc.
8. What is procedure for refilling prescriptions:
  - a. Is physician required to designate on prescription length of time it is to cover and whether or not it is to be refilled?
  - b. When patient requests authorization for refill is there any clearance with physician? Describe in detail
  - c. What procedures for refills when physician dispenses drugs
  - d. When drug store requests authorization for refills is there any clearance with physician
9. Has the department a special arrangement for purchasing and dispensing insulin:
  - a. Describe in detail
  - b. Plan for purchase of hypodermic needles, cotton, alcohol, etc. Is this on a prescription basis?
10. What provision (if any) is made for purchase of drugs, sickroom supplies, patent medicines, etc., which patient may request and investigator concur in believing that patient should have these items
11. What plan is in operation for supplying drugs to narcotic addicts. (This is exclusive of morphine and codeine provided for acute illness or terminal phase of chronic illness)



12. Miscellaneous: List here any facts which are not covered above but which have a bearing on the purchase of drugs
13. Have there been deductions on drugs? Give examples

III. Other Medical Items to be Covered as to Policy and Procedure for Each Category:

- |                                   |                                |
|-----------------------------------|--------------------------------|
| 1. Ambulance                      | 11. Nursing homes              |
| 2. Clinic care                    | 12. Obstetrics                 |
| 3. Dental care including dentures | 13. Optometrists               |
| 4. Drugs                          | 14. Physiotherapy              |
| 5. Eye examination                | 15. Prosthetic appliances      |
| 6. Glasses—artificial eyes        | 16. Radium                     |
| 7. Hospital care                  | 17. Sick room supplies         |
| 8. Laboratory services            | 18. Specialists or consultants |
| 9. Mileage                        | 19. Tuberculosis               |
| 10. Nursing care                  | 20. V.D.                       |
|                                   | 21. X-ray                      |

*Most Important*

1. Prosthetic appliances
2. Mileage as to policy and price and zones if any
3. Glasses
4. Dental
5. X-rays
6. Hospital care—who authorizes care

## Appendix F

### LAWS OF NEW YORK.—By Authority

#### CHAPTER 682

AN ACT to amend the public welfare law, in relation to medical care and hospitalization

Became a law April 22, 1940, with the approval of the Governor. Passed, three-fifths being present

*The People of the State of New York, represented in Senate and Assembly, do enact as follows:*

Section 1. Section eighty-three of chapter five hundred and sixty-five of the laws of nineteen hundred twenty-nine, entitled "An act in relation to the public welfare, constituting chapter forty-two of the consolidated laws," as amended by chapter four hundred and ninety-four of the laws of nineteen hundred thirty-five, is hereby amended to read as follows:

§ 83. Responsibility for providing medical care. The public welfare district shall be responsible for providing necessary medical care for all persons under its care, and for such persons otherwise able to maintain themselves, who are unable to secure necessary medical care. The determination as to the medical care necessary for any person shall be made with the advice of a physician. Such care may be given in dispensaries, hospitals, the person's home or other suitable place.

§ 2. Section eighty-five of such chapter is hereby amended to read as follows:

§ 85. Care in hospitals. A public welfare district shall provide needed care for sick and disabled persons in a hospital maintained by the municipality or in any other hospital visited, inspected and supervised by the state board of social welfare. It may contract with such other hospital to pay such sum for the care of sick persons as may be agreed upon.

As far as practicable, no patient whose care is to be a charge on a public welfare district, or a subdivision thereof, shall be admitted to a hospital without the prior approval of the public welfare official responsible for his support. In any case where the patient is a public charge, the public welfare official may, when in the opinion of a physician the condition of the patient permits, transfer such patient to another hospital or provide care in any other suitable place.

If, in case of emergency, a patient is admitted without prior authorization of the public welfare official empowered to approve payment for such care, and the hospital wishes to receive payment from public funds for such patient, the hospital shall, within forty-eight hours of the admission, Sundays and legal holidays excepted, send to such official a report of the facts of the case, including a statement of the physician in attendance as to the necessity of the immediate admission of such patient to the hospital. If the settlement of the patient is not known by the hospital, such notice shall be sent to the commissioner of the public welfare district in which the hospital is located, and such commissioner shall be responsible for making an investigation to discover whether any public welfare district or the state is liable for payment for the care of such patient. The cost of the care of such a patient shall be a charge against the public welfare district only when authorized by the commissioner.

§ 3. This act shall take effect immediately.

STATE OF NEW YORK, }  
Department of State. } ss:

I have compared the preceding with the original law on file in this office, and do hereby certify that the same is a correct transcript therefrom and of the whole of said original law.

MICHAEL F. WALSH  
Secretary of State

## Appendix G

STATE OF NEW YORK  
TEMPORARY LEGISLATIVE COMMISSION TO FORMULATE A LONG  
RANGE STATE HEALTH PROGRAM  
STUDY OF HOSPITAL AND MEDICAL CARE OF WARD  
PATIENTS IN TEN AREAS IN NEW YORK STATE

Form 1

[CONFIDENTIAL]

### INFORMATION FROM HOSPITAL RECORDS

<i>Patient</i>	<i>Hospital</i>
Name.....	Name.....
Address.....	Address.....
Age.....	Patient's case number.....
Sex.....	
Occupation.....	
Diagnosis on discharge.....	Date.....
Diagnosis on admission.....	Date.....
Analysis of final hospital note as (check) to results of treatment	
	Complete recovery.....
	Greatly improved.....
	Arrested.....
	No improvement.....
	Incurable diagnosis.....
	Died.....
	Left hospital against advice.....

Was patient treated in hospital by (check) 1. Referring physician.....  
2. Family physician..... 3. Hospital staff physician.....

#### *Hospital Social Service:*

- (1) Was case investigated by:
- |                                |          |         |
|--------------------------------|----------|---------|
| a. Social service.....         | yes..... | no..... |
| b. Hospital credit office..... | yes..... | no..... |

Was responsibility of payment of hospital care assigned to (check one applying)

1. Patient or family.....
- |  |  |
|--|--|
| a. Cash payment.....                           |  |
| b. Deferred payment.....                       |  |
| c. Hospital or medical care benefit clubs..... |  |

2. Public Welfare Agency.....  
Specify Agency.....

Authorization for

a. Medical care only.....	
b. Medical and hospital care.....	
c. Relief status state category.....	

3. Private Welfare Agency.....  
Specify Agency.....
4. Free care by voluntary hospital.....

#### *Follow-up Service:*

To whom was patient referred for follow-up

- |                           |  |
|---------------------------|--|
| a. Private physician..... |  |
| b. Clinic. 1. Public..... |  |
| 2. Private.....           |  |



## Appendix H

### STATE OF NEW YORK

#### TEMPORARY LEGISLATIVE COMMISSION TO FORMULATE A LONG RANGE STATE HEALTH PROGRAM

#### STUDY OF HOSPITAL AND MEDICAL CARE OF WARD PATIENTS IN TEN AREAS IN NEW YORK STATE

##### Form 2

#### STATEMENTS OF THE PATIENT OR PATIENT'S FAMILY SECURED BY FOLLOW-UP AFTER HOSPITAL DISCHARGE

Patient's name..... Address.....  
Color..... Age..... Sex..... Occupation.....  
Name of hospital where treated.....  
Address of hospital where treated.....  
State complaint or illness for which admitted to hospital.....  
.....  
.....

Date of first symptoms or complaint.....

Remarks (nurse to record date of first definite and important symptom or symptoms  
attributable to illness for which patient entered the hospital)

##### MEDICAL CARE

Date first seen by a physician for this illness.....  
Where was the scene of this visit? (check) physician's office.....  
Patient's home..... Clinic..... Hospital..... Other (specify).....  
Date applied for admission to hospital.....  
Date admitted to hospital.....  
Date discharged from hospital.....

##### REASON FOR DELAY (if any) IN SECURING MEDICAL CARE (check)

A. Did not seek medical care

##### Reason

- .....(1) Self neglect  
.....(2) Did not realize necessity  
.....(3) Unable to pay for physician's service  
.....(4) Physician not available

B. Refused authorization of physician's services by Public Welfare Official.

State reasons given for refusal.....

C. Refused free medical care by private physician.

D. Free clinic not available.

E. Refused free medical care by clinic.

State name of clinic.....

Reasons given for refusal.....

##### SELF MEDICATION

Did you doctor yourself for this illness before seeking services of a physician  
.....yes.....no

How long?.....

Did you use "home remedies".....yes.....no

Name remedies used.....  
.....

## Who recommended home remedies (check)

member of family.....neighbor.....  
 druggist.....newspaper.....radio.....  
 others (specify).....

## PHYSICIAN'S SERVICES PRIOR TO HOSPITALIZATION

Do you have a regular family physician?.....yes.....no  
 Name of family physician.....  
 Have you ever had a complete physical examination?.....yes.....no  
 (nurse to explain what a complete physical examination consists of)

## Check items:

.....(1) All parts of body examined	.....(7) Rectal examination
.....(2) Clothes removed	.....(8) Urinalysis
.....(3) Use of stethoscope	.....(9) Blood count
.....(4) Blood pressure reading	.....(10) Blood test
.....(5) Genital examination in males	.....(Wasserman)
.....(6) Vaginal examination in females	.....(11) X-rays
	.....(12) Others (sputum ex-
	amination, etc.)

Specify.....

State date of last such examination.....  
 Was this examination made in connection with application for life insurance?  
 .....yes.....no  
 Was this examination performed by a private physician?.....yes.....no  
 Where was this examination performed? (check) physician's office.....  
 your home.....clinic.....hospital.....school.....  
 industrial clinic.....other (specify).....  
 Do you have a complete examination at regular intervals.....yes.....no  
 regular interval.....(state time)

## PHYSICIAN'S SERVICES IN PRESENT ILLNESS AND PRIOR TO HOSPITAL ADMISSION

Were you seen by a private physician for this illness prior to admission to the hospital?.....yes.....no  
 How long were you under physician's care for this illness.....days.....  
 weeks.....months.....  
 How many visits did you make to physician's office for this illness?.....  
 How many visits did physician make to your home for this illness?.....  
 Did your physician call a consultant?.....yes.....no  
 Did you consult more than one private physician for this illness and prior to hospital or outpatient department admission?.....yes.....no  
 Number of physicians other than first.....  
 How many of these physicians were specialists?.....  
 How many of these physicians were general practitioners?.....  
 How many visits did you have by these physicians for this illness?  
 .....Physicians office  
 .....Your home  
 .....Total

While under care of private physician for this illness (1) did you have a complete examination.....yes.....no  
 Were laboratory tests performed to your knowledge.....yes.....no  
 As part of examination during this illness were following procedures performed (check)  

.....(1) All parts of body examined	.....(7) Rectal examination
.....(2) Clothes removed	.....(8) Urinalysis
.....(3) Use of stethoscope	.....(9) Blood count
.....(4) Blood pressure reading	.....(10) Blood test
.....(5) Genital examination in males	.....(Wasserman)
.....(6) Vaginal examination in females	.....(11) Others (sputum ex-
	amination, etc.)

Specify.....

Did you or your family pay for physician's services?	yes	no
Did some other agency pay for physician's services?	yes	no
Name agency		
Did physician give you credit for costs of treatment?	yes	no
Did physician give free treatment?	yes	no

CLINIC SERVICES PRIOR TO HOSPITALIZATION FOR THIS ILLNESS

HOSPITAL CARE (for this illness)

..... Private physician  
..... Public physician (state title).....  
..... Public clinic  
..... Private clinic  
..... Another hospital  
..... Public welfare officer (state title).....  
..... Private welfare agency (specify).....  
..... Nurse public health (specify agency).....  
..... Other (specify).....  
..... Applied voluntarily

PERSON OR AGENCY RESPONSIBLE FOR HOSPITAL CARE EXPENSE (check)

## FOLLOW-UP SERVICE AFTER HOSPITAL DISCHARGE

(a) Private physician  
(b) Public salaried physician  
(c) Clinic (1) Public (specify)  
(2) Private (specify)





from hospital case histories and the completion of a questionnaire form by nurse visits to the discharged hospital patients in their homes.

During the analysis of these ward cases, the Commission finds that a number of these patients are either referred to the ward service of the hospital or treated at the wards by their private physician. Where such conditions exist, it is the desire of the Legislative Health Commission to notify such private physician that his given patient or patients from the ward service has or will be visited by one of the four registered nurses making the home investigations on such patients. A list of such patients for whom you have been named as the private physician is attached.

The Legislative Health Commission wishes to sincerely express to the physicians and the hospitals of the State that this investigation is a fact finding study of the medically indigent or border line group of cases and is not designed to be interpreted as a method of applying critical analysis to the medical practices of any individual physician or hospital.

I wish to express my appreciation for your cooperation in this study.

Sincerely yours,

LEE B. MAILLER,

*Chairman*

# Appendix I

## STUDY OF PATIENTS DISCHARGED FROM HOSPITAL WARDS, 1939

New York State (Exclusive of New York City)

### STATISTICAL PUNCHED CARD CODE

COL. 1. HOSPITAL		COL. 7. CIVIL STATUS	
9	hospital A	9	single
8	hospital B	6	married
7	hospital C	7	widowed
6	hospital D	6	divorced
5	hospital E	5	separated
4	hospital F	X	unknown status
3	hospital G		
2	hospital H		
1	hospital I		
Y	hospital J <sub>2</sub>		
X	hospital J <sub>1</sub>		
COLS. 2-4. SERIAL NUMBER		COL. 8. OCCUPATIONAL GROUP	
		9	professional and semi-professional
		8	white collar
		7	trade (proprietor and sales)
		6	agricultural
		5	industrial (include laborer, unspecified and W. P. A.)
		3	domestic
		2	housewife
		1	non-worker (child, student, retired)
		O	unemployed
		Y	transportation
		X	unknown occupation
COL. 5. AGE		COL. 9. DAYS IN HOSPITAL	
9	under 1 year	9	less than 1 day
8	1 year and under two years	8	1 day and less than 3 days
7	2 years and under 5 years	7	3 days and less than 1 week
6	5 years and under 10 years	6	1 week and less than 2 weeks
5	10 years and under 15 years	5	2 weeks and less than 3 weeks
4	15 years and under 20 years	4	3 weeks and less than 4 weeks
3	20 years and under 25 years	3	4 weeks and less than 5 weeks
2	25 years and under 35 years	2	5 weeks and less than 6 weeks
1	35 years and under 45 years	1	6 weeks and less than 7 weeks
O	45 years and under 55 years	O	7 weeks and less than 8 weeks
Y	55 years and under 65 years	Y	8 weeks and less than 12 weeks
X	65 years and over	X	12 weeks and over (specify)
R	unknown age	R	unknown length of hospital stay
COL. 6. SEX AND COLOR		COL. 10. CHANGE OF DIAGNOSIS BETWEEN ADMISSION AND DISCHARGE	
5	male white	9	same diagnosis on admission and discharge or recovered on discharge
4	female white	8	diagnosed in hospital (include symptoms only on admission)
3	male negro	7	no admission diagnosis stated
2	female negro	6	diagnosis radically altered between admission and discharge
1	male indian	O	no diagnoses stated
O	female indian		
Y	male chinese		
X	female chinese		



## COLS. 11 AND 12 DISCHARGE DIAGNOSIS

INFECTIOUS DISEASES	Welfare Council List Numbers
99 Tuberculosis of the respiratory system.....	0
98 All other forms of tuberculosis.....	1, 2, 3, 4, 5, 6, 9
97 Syphilis, all forms.....	10, 11, 12, 13, 19
96 Gonorrhea, all forms.....	20, 21, 22, 29
95 Influenza (grippe), common cold.....	41, 42
94 Acute poliomyelitis, polioencephalitis.....	44
93 All other general infections and diseases due to higher plant and animal parasites.....	30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 43, 45, 46, 47, 48, 49, 50, 51, 59
NEOPLASMS	
89 Malignant neoplasm of the digestive system.....	60, 61, 62, 63, 64
88 Malignant neoplasm of the female genital system and breast.....	66, 67, 68, 69
87 All other malignant neoplasm.....	65, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 89
85 Nonmalignant neoplasm of the digestive system.....	90
84 Nonmalignant neoplasm of the female genital system and breast.....	92, 93, 94
83 All other nonmalignant neoplasm (include verruca vulgaris).....	91, 95, 96, 97, 98, 99, 109
81 Malignancy unknown, neoplasm of the digestive system	
80 Malignancy unknown, neoplasm of the female genital system and breast.....	
8Y Malignancy unknown, all other neoplasm.....	
RHEUMATIC DISEASES, DISORDERS OF METABOLISM AND ENDOCRINE GLANDS, VITAMIN DEFICIENCIES	
79 Rheumatic diseases.....	110, 111, 112, 113, 114, 115, 116, 119
77 Diabetes mellitus, uncomplicated.....	120
76 Diabetes mellitus, complicated.....	121, 122
75 All other metabolic conditions (include malnutrition).....	123, 129, 623
73 Disorders of the thyroid gland.....	130, 131, 132
72 All other endocrine conditions.....	133, 134, 135, 136, 139
70 Vitamin deficiencies.....	140, 141, 142, 149
TRAUMATIC CONDITIONS, POISONINGS	
90 Traumatic fractures.....	150, 151, 152, 153, 154, 155, 156, 157, 159
9Y All other traumatic conditions.....	160, 161, 162, 163, 164, 165, 166, 167, 168, 169, 170, 171, 172, 173, 174, 175, 176, 177, 178, 179, 180, 189
9X Poisonings, including alcoholism.....	190, 191, 200, 201, 202, 203, 204, 205, 206, 209
PUERPERAL STATE	
69 Pregnancy without indication of obstetrical compli- cations, delivered.....	210
68 Pregnancy with obstetrical complications, delivered...	220, 221, 222, 223, 224, 225, 226, 227, 228, 229, 230, 239
67 Abortion.....	
66 Pregnancy, outcome unknown, including untermi- nated pregnancy.....	

COLS. 11 AND 12 DISCHARGE DIAGNOSIS — *continued*

NEUROLOGICAL AND PSYCHIATRIC CONDITIONS		Welfare Council List Numbers
59 Vascular cerebral accident.....	276, 277, 278	
58 All other conditions of the nervous system in general..	270, 271, 272, 273, 274, 275, 279, 280, 281, 282, 283, 284, 285, 286, 287, 288, 289, 290, 291, 292, 293, 294, 299	
56 Psychiatric conditions.....	300, 301, 302, 303, 304, 305, 306, 308, 309	
DISEASES OF THE EYE AND EAR		
54 Cataract and glaucoma.....	312, 313	
53 All other diseases of the ophthalmic system.....	310, 311, 314, 315, 316, 317, 318, 319, 320, 321, 322, 323, 324, 325, 326, 327, 328, 329	
50 Mastoiditis and otitis media.....	330, 331, 332, 333	
5X All other diseases of the auditory system.....	334, 339	
CARDIO-VASCULAR DISEASES		
49 Cardiac diseases (except syphilitic and rheumatic)...	340	
47 General arteriosclerosis.....	350	
46 Other arterial diseases.....	351, 352, 353, 354, 369 in part	
45 Varices (except hemorrhoids).....	360, 361, 362	
44 All other venous and capillary diseases.....	355, 356, 357, 358, 359, 369 in part	
BLOOD, SPLENIC, LYMPHATIC DISEASES		
39 Pernicious anemia.....	372	
38 All other diseases of the hemic system.....	370, 371, 373, 374, 375, 376, 377, 378	
36 Acute lymphadenitis, abscess of lymph-nodes.....	379	
35 All other diseases of the lymphatic system.....	380, 389	
DISEASES OF THE RESPIRATORY SYSTEM		
29 Infectional hypertrophy of tonsil, adenoid.....	390	
27 Sinusitis.....	397	
26 All other diseases of the upper respiratory tract.....	391, 392, 393, 394, 395, 396, 398, 399	
25 Broncho-pneumonia.....	400	
24 Lobar pneumonia.....	401	
23 Pneumonia, unspecified.....	402	
22 All other forms of pneumonia.....	403	
21 Chronic bronchitis.....	411 in part	
20 Bronchial asthma.....	417	
2Y Pleural conditions.....	409, 412, 413, 414, 415, 420	
2X All other diseases of the lower respiratory tract.....	410, 411 in part, 416, 418, 419, 421, 422, 429	
DISEASES OF THE DIGESTIVE SYSTEM		
19 Diseases of teeth and gums.....	430, 431	
18 Other diseases of mouth and pharynx.....	432, 433, 434, 435, 436, 437, 439	
17 Ulcer of stomach and duodenum.....	444, 445, 446, 447	
16 Gastro-enteritis, colitis, colitis ulcerosa.....	450, 451	
15 Appendicitis.....	455, 456, 457	
14 Hemorrhoids.....	462	
13 All other conditions of rectum and anus.....	463, 464, 465, 466, 467	

COLS. 11 AND 12 DISCHARGE DIAGNOSIS — *continued*Welfare Council  
List Numbers

12 All other diseases of the gastro-intestinal tract and pancreas.....	440, 441, 442, 443, 448, 449, 452, 453, 454, 458, 459, 460, 461, 469, 480, 489
10 Cirrhosis of liver.....	470, 471
1Y Other liver diseases.....	472, 473, 474
1X Diseases of the bile passage.....	475, 476, 477, 478, 479

PERITONEAL AND OTHER ABDOMINAL CONDITIONS;  
HERNIAS

60 Peritoneal adhesions.....	494
6Y Other conditions of the abdominal cavity.....	490, 491, 492, 493, 495, 496
6X Hernia.....	497, 498, 499, 509

## DISEASES OF THE URO-GENITAL SYSTEM

09 Diseases of the kidney parenchyma.....	510, 511, 512 in part, 513, 514, 515, 516, 518
08 Calculus in the urinary system.....	520, 521, 525
07 All other diseases of the urinary system.....	512 in part, 517, 519, 522, 523, 524, 526, 527, 528, 529
06 Benign hypertrophy of prostate.....	530
04 Phimosis.....	537, 622
05 All other diseases of the male genital system.....	531, 532, 533, 534, 535, 536, 538, 539, 549
03 Salpingitis, oöphoritis (non-specific).....	550, 551
02 Diseases of uterus and cervix (except displacements) ..	552, 553, 554
01 Displacement of uterus, rectocele, cystocele.....	555, 559
00 Vulvitis, vaginitis (non-specific).....	557
OX All other non-puerperal diseases of the female genital system.....	556, 558, 562, 569
OY Non-puerperal diseases of female breast.....	560, 561

## DISEASES OF SKIN, CELLULAR TISSUE

Y9 Furuncle, furunculosis, carbunculus, cellulitis, superficial ulcer.....	570, 571, 572, 573, 574, 575, 576
Y8 Other infections and infestations of skin (except verruca vulgaris, see 83).....	579, 580, 581, 582
Y7 All other diseases of skin.....	577, 578, 583, 584, 585, 586, 587, 589

## NON-TRAUMATIC DISEASES OF BONES AND ORGANS OF MOVEMENT

X9 Osteomyelitis.....	590, 591, 592, 593, 594, 595
X8 Other infections of the musculo-skeletal system.....	600, 610, 611, 612
X7 Orthopedic defect for correction.....	596, 597, 598, 599, 601, 602, 603, 604, 605, 606, 607, 608, 609, 614
X6 All other conditions of the musculo-skeletal system...	613, 619

## CONDITIONS NOT ELSEWHERE CLASSIFIED

XY For diagnosis only.....	625 in part
YY Undiagnosed conditions.....	628
XX Not stated.....	
7X Not ill.....	



## COL. 13. ACUTE? SURGICAL?

- 9 acute-chronic not applicable, non-surgical
- 8 acute, non-surgical
- 7 chronic, non-surgical
- 6 acute-chronic unknown, non-surgical
- 5 acute-chronic not applicable, surgical
- 4 acute, surgical
- 3 chronic, surgical
- 2 acute-chronic unknown, surgical
- 1 acute-chronic not applicable, surgery unknown
- O acute, surgery unknown
- Y chronic, surgery unknown
- X acute-chronic unknown, surgery unknown

## COL. 14. CONDITION ON DISCHARGE

- 8 improved ("complete recovery," "improved," "arrested")
- 6 unimproved ("no improvement," "incurable diagnosis")
- 4 left against advice, improved
- 3 left against advice, unimproved
- 2 diagnostic admission, improved
- 1 diagnostic admission, unimproved
- O deceased
- X unknown condition

## COL. 15. PHYSICIAN WHO GAVE TREATMENT IN HOSPITAL

- 9 referring physician
- 8 family physician
- 7 hospital staff physician
- 6 referring and family physicians
- 5 referring and hospital physicians
- 4 family and hospital physicians
- 3 referring, family and hospital physicians
- 2 referred to and treated in hospital by family physician
- X unknown physician

## COL. 16. RESPONSIBILITY FOR HOSPITAL PAYMENT

- 9 patient (or family)
- 8 patient and city hospital (area C only)
- 7 public welfare agency, authorized
- 6 public welfare agency, pending
- 5 workmen's compensation
- 4 private welfare agency
- Y other agency (specify)
- X unknown responsibility

## COL. 17. METHOD OF PAYMENT (use only when Col. 16 is coded 9)

- 9 Cash
- 8 deferred
- 7 benefit club
- O neither patient nor public agency
- X unknown method of payment

## COL. 17. WELFARE CATEGORY (use only when Col. 16 is coded 7 or 6)

- 9 local department of public welfare
- 8 home relief
- 7 veteran relief
- 6 old age assistance
- 5 aid to dependent children
- 4 assistance to the blind
- 3 foster care
- 2 public hospital
- O neither patient nor public agency
- X unknown agency

## COL. 18. FOLLOW-UP ADVISED BY HOSPITAL

- 9 physician (include city physician)
- 8 physician plus clinic
- 7 physician plus nurse
- 6 clinic
- 5 clinic plus nurse
- 4 same hospital for further treatment
- 3 other hospital (include sanatorium or convalescent home)
- 2 non-medical institution (school or county home)
- 1 none reported
- O deceased
- Y other follow-up (specify)

## COL. 19. TYPES OF TIME PERIOD CODES

- 9 P code
- 7 Col. 20 D, Col. 36 D, Col. 48 D
- 6 Col. 20 D, Col. 36 D, Col. 48 L
- 5 Col. 20 D, Col. 36 L, Col. 48 L
- 4 Col. 20 D, Col. 36 L, Col. 48 D
- 3 Col. 20 L, Col. 36 L, Col. 48 L
- 2 Col. 20 L, Col. 36 L, Col. 48 D
- 1 Col. 20 L, Col. 36 D, Col. 48 D
- O Col. 20 L, Col. 36 D, Col. 48 L

## COL. 20. INTERVAL BETWEEN FIRST SYMPTOM AND FIRST MEDICAL ATTENTION

Use D code when dates are definitely stated and maximum interval is one month or less

- D code (for definite short intervals)
- O less than 1 day
- 1 1 day and less than 2 days
- 2 2 days and less than 3 days
- 3 3 days and less than 4 days
- 4 4 days and less than 5 days
- 5 5 days and less than 6 days
- 6 6 days and less than 1 week
- 7 1 week and less than 2 weeks
- 8 2 weeks and less than 3 weeks
- 9 3 weeks and less than 1 month

Use L code when dates are definitely stated or maximum interval is over one month

- L code (for long intervals)
- O less than 1 month
- 1 1 month and less than 2 months

- 2 2 months and less than 3 months
- 3 3 months and less than 6 months
- 5 6 months and less than 9 months
- 6 9 months and less than 1 year
- 7 1 year and less than 2 years
- 8 2 years and less than 5 years
- 9 5 years and less than 10 years
- Y 10 years and over (specify)
- X unknown period

Use P code for all cases in which Cols.  
11 and 12 are coded 69, 68 or 66

**P CODE MONTH OF PREGNANCY FIRST  
ANTE-PARTUM CARE**

- 1 first month of pregnancy
- 2 second month of pregnancy
- 3 third month of pregnancy
- 4 4 fourth month of pregnancy
- 5 fifth month of pregnancy
- 6 sixth month of pregnancy
- 7 seventh month of pregnancy
- 8 eighth month of pregnancy
- 9 ninth month of pregnancy (except as  
indicated for O and Y)
- O first seen within 24 hours of hospitali-  
zation
- Y no medical attention before hospitali-  
zation
- X unknown month of pregnancy

**COL. 21. INTERVAL BETWEEN FIRST  
MEDICAL ATTENTION AND HOSPITAL  
ADMISSION**

Same codes as Col. 20. Use D code  
when Col. 20 is in D code; use L code  
when Col. 20 is in L code

**COL. 21. MONTH OF PREGNANCY IN  
WHICH LABOR OCCURRED**

Use this code when Col. 20 is in P code  
9 at term (assume unless otherwise  
specified)

- 8 eighth month of pregnancy
- 7 seventh month of pregnancy
- 6 sixth month of pregnancy
- 5 fifth month of pregnancy

O undelivered at time of hospital dis-  
charge (Cols. 11 and 12 coded 66)

**COL. 22. INTERVAL BETWEEN FIRST  
SYMPTOM AND HOSPITAL ADMISSION**

Same codes as Col. 20. Use D code when  
Col. 20 is in D code; use L code when  
Col. 20 is in L code

**COL. 22. PLACE WHERE DELIVERY  
OCCURRED**

Use this code when Col. 20 is in P code  
5 labor in hospital

- 4 labor at home attended by physician
- 3 labor at home unattended by physician
- O undelivered at time of hospital dis-  
charge (Cols. 11 and 12 coded 66)

**COL. 23. INTERVAL BETWEEN HOSPITAL  
APPLICATION AND HOSPITAL ADMISSION**

All codes same as Col. 20 of D code except:  
9 3 weeks and over (specify)

- Y hospital arrangements not made by  
patient or family
- X unknown interval

## Appendix J

### 1. Hospital Care

#### TEMPORARY LEGISLATIVE COMMISSION TO FORMULATE A LONG RANGE STATE HEALTH PROGRAM

346 Broadway, New York, N. Y.

Inquiry as to the relief status of patients receiving ward care in hospitals in the month of November, 1939.

Name of Hospital.....

Address.....

#### A. TOTAL NUMBER OF PATIENTS RECEIVING WARD CARE IN NOVEMBER (see general note)

##### *Relief Status of Patient*

PAYMENT FOR HOSPITAL CARE	(a) Receiv- ing public relief *	(b) On WPA †	(c) Not receiving (a) public relief or (b) WPA, but referred or accepted as public charges to receive hospital care ‡	(d) Not receiving (a) public relief or (b) WPA, and not referred or accepted as public charges to receive hospital care §	Total
1. Patient expected to pay full ward rate					
2. Patient expected to pay partial ward rate					
3. Accepted public charge					
4. Referred to Department of Hospitals, decision pending (include any cases referred that are not entirely approved by Department of Hospitals)					
5. Free cases (not referred or accepted as public charges)					
6. Status not determined ¶					
Total (see general note)					



**General note:**

Do not count cases more than once. Total of lines 1, 2, 3, 4, 5, 6, and total of columns (a), (b), (c), and (d) should equal the grand total, i.e., the total number of cases receiving ward care.

**Explanatory notes on "Relief Status of Patient":**

\* "(a) Receiving public relief." Enter cases where the patient immediately prior to admission to the hospital was receiving public relief, or where patient is a member of a family currently receiving public relief, such as home relief, veteran relief, old age assistance, assistance to the blind, aid to dependent children, or care in a boarding home or institution. Do not include cases receiving relief in the form of hospital care at public expense.

† "(b) On WPA." Enter cases where the patient immediately prior to this illness was employed on WPA or where some other member of his family is currently employed on WPA. If a WPA recipient is also receiving home relief, classify under WPA only.

‡ "(c) Not receiving (a) public relief or (b) WPA, but referred or accepted as public charges to receive hospital care." Include only cases not receiving (a) public relief or (b) WPA and who are either accepted as public charges to receive hospital care or who have been referred for such acceptance.

§ "(d) Not receiving (a) public relief or (b) WPA, and not referred or accepted as public charges to receive hospital care." Include only cases not receiving any form of public relief, WPA, or cases referred or accepted as public charges to receive hospital care.

**Explanatory note on A — line 6, "Status not determined":**

¶ Include here cases not classified under lines 1, 2, 3, 4, and 5 — such as those cases where it has not yet been determined whether patient will pay wholly or partially, whether he will be referred as a public charge, or whether he will be given free care.

**B. WARD RATES FOR PAYING PATIENTS:**

Per diem rate for paying medical and surgical ward patients \$.....

Extras charged. Yes..... No.....

Average per diem payment of paying ward patients \$.....

**C. MEDICAL STAFF:**

Are staff physicians paid by hospital. Yes..... No.....

If yes, number of physicians paid.....

Closed staff. Yes..... No.....

**Return form when completed to:**

Temporary Legislative Commission to Formulate a Long Range State Health Program, 346 Broadway, New York, N. Y.

2. *Clinic Care.*TEMPORARY LEGISLATIVE COMMISSION TO FORMULATE A LONG  
RANGE STATE HEALTH PROGRAM

346 Broadway, New York, N. Y.

Inquiry as to the relief status of persons applying for care in out-patient departments of hospitals in the month of November, 1939.

Name of Hospital.....

Address.....

## A. APPLICATIONS FOR CLINIC CARE IN NOVEMBER, 1939:

1. Total number of cases accepted for care during November.....  
(New cases and old cases reapplying).
2. Total number of cases rejected during November.....
3. Total number of cases in which decision not made on November 30.....

## B. CASES ACCEPTED DURING NOVEMBER (see general note):

*Relief Status of Applicant*

PAYMENT OF CLINIC ADMISSION FEES	(a) Receiving public relief *	(b) On WPA †	(c) Not receiving (a) public relief * or (b) WPA †	(d) Total
1. Patient paying full clinic admission fees				
2. Free care				
Total accepted cases (see general note)				
C. CASES REJECTED DURING NOVEMBER (see general note):				
<i>Reason for Rejection:</i>				
1. Patient can afford private physician				
2. Private physician will treat free or give credit				
3. Clinic care not needed				
4. Already under care in another clinic				
5. Referred to other clinic (voluntary hospital)				
6. Referred to other clinic (public hos- pital)				
7. Lack of facilities (clinics overcrowded)				
8. Other				
Total rejected cases (see general note)				

## D. TOTAL NUMBER OF PATIENTS TREATED AND CLINIC VISITS DURING NOVEMBER, 1939:

	No. of patients	No. of visits
1. Full payment of clinic admission fees		
2. Free		
Total		

## E. PAYMENT FOR PRESCRIPTIONS, APPLIANCES AND OTHER SERVICES DURING NOVEMBER 1939

	No. of patients
1. Full payment by patient of clinic charges for prescriptions, appliances and other services	
2. Partial payment by patient of clinic charges for prescriptions, appliances and other services	
3. Prescriptions, appliances and other services given entirely free	
4. Payment for prescriptions, appliances and other services by Department of Welfare	
Total	

*General note on Cases Accepted and Rejected in November:*

Do not count cases more than once. Total of lines B-1, and 2, and total of columns B-(a), (b) and (c) should each equal the total number of patients accepted for clinic care during the month. Similarly under C, the total of lines 1-8 and total of columns (a), (b) and (c) should each equal the total number of rejected cases during the month.

*Explanatory notes on "Relief Status of Applicant":*

\* "(a) Receiving public relief."

Enter cases where, according to applicant's statement, he as an individual or as a member of a family, is receiving any form of public relief such as home relief, veteran relief, old age assistance, assistance to the blind, aid to dependent children, care in a boarding home or in an institution.

† "(b) On WPA."

Enter cases where the applicant states that he is working on WPA or was working on WPA immediately prior to this illness, or that a member of his family is currently working on WPA. If a WPA recipient is also receiving home relief, classify such a case under WPA only.

Return form when completed to:

Temporary Legislative Commission to Formulate a Long Range State Health Program, 346 Broadway, New York, N. Y.



## Appendix K

### 1. Hospital Care

#### TEMPORARY LEGISLATIVE COMMISSION TO FORMULATE A LONG RANGE STATE HEALTH PROGRAM

Room 412, The Capitol, Albany, N. Y.

Inquiry as to the relief status of patients receiving ward care in hospitals in the month of November, 1939.

Name of Hospital.....

Address.....

#### A. TOTAL NUMBER OF PATIENTS RECEIVING WARD CARE IN NOVEMBER (see general note): *Relief Status of Patient*

PAYMENT FOR HOSPITAL CARE	(a) Receiving public relief other than medical or hospital care*	(b) On WPA†	(c) Not receiving public relief (a) or WPA (b)	Total
1. Patient expected to pay full ward rate				
2. Patient expected to pay partial ward rate				
3. Accepted public charge				
4. Referred to public welfare department, decision pending (public hospitals omit)				
5. Free cases (public hospitals omit)				
6. Status not determined ‡				
Total (see general note)				

#### *General note:*

Do not count cases more than once. Total of lines 1, 2, 3, 4, 5 and 6, and total of columns (a), (b), and (c) should equal the grand total, i.e., the total number of cases receiving ward care.

#### *Explanatory notes on "Relief Status of Patient":*

\* "(a) Receiving public relief other than medical or hospital care." Enter cases where the patient immediately prior to admission to the hospital was receiving public relief, or where patient is a member of a family currently receiving public relief, such as home relief, veteran relief, old age assistance, assistance to the blind, aid to dependent children, or care in a boarding home or institution.

† "(b) On WPA." Enter cases where the patient immediately prior to this illness was employed on WPA or where some other member of his family is currently employed on WPA. If a WPA recipient is also receiving home relief, classify under WPA only.

#### *Explanatory note on A — line 6, "Status not determined":*

‡ Include here cases not classified under lines 1, 2, 3, 4 and 5 — such as those cases where it has not yet been determined whether patient will pay wholly or partially, whether he will be referred as a public charge, or whether he will be given free care.

*To be filled out by voluntary hospitals only*

**B. WARD RATES:**

1. Ward Rates for Paying Patients:  
Per diem rate for paying ward patients \$..... Extras charged. Yes.....No.....  
Average per diem payment of paying ward patients \$.....
2. Ward Rates Paid by Public Welfare Departments:  
Per diem rate paid by public welfare department \$..... All inclusive. Yes.....No.....
3. Extras Paid by Public Welfare Department in Addition to Per Diem Rate:

			Rate
Operating room.....	Yes.....	No.....	\$.....
Anesthesia.....	Yes.....	No.....	\$.....
Laboratory.....	Yes.....	No.....	\$.....
X-ray.....	Yes.....	No.....	\$.....
Blood transfusion.....	Yes.....	No.....	\$.....
Drugs.....	Yes.....	No.....	\$.....
Medical supplies.....	Yes.....	No.....	\$.....
Special nursing.....	Yes.....	No.....	\$.....
Other (specify).....	Yes.....	No.....	\$.....

**C. OBSTETRICAL CARE:**

State any special arrangement with public welfare department for this type of case.

**D. MEDICAL STAFF:**

Staff physicians paid by hospital. Yes..... No.....  
If Yes, number of physicians paid.....  
Closed staff. Yes..... No.....

Return form when completed and address any inquiries to:

Temporary Legislative Commission to Formulate a Long Range State Health Program,  
Room 412, The Capitol, Albany, N. Y.

October 31, 1939.

## 2. Clinic Care

TEMPORARY LEGISLATIVE COMMISSION TO FORMULATE A LONG  
RANGE STATE HEALTH PROGRAM

346 Broadway, New York, N. Y.

Inquiry as to the relief status of persons applying for care in out-patient departments of hospitals in the month of November, 1939.

Name of Hospital.....

Address.....

## A. APPLICATIONS FOR CLINIC CARE IN NOVEMBER 1939:

1. Total number of cases accepted for care during November.....  
(New cases and old cases reapplying).
2. Total number of cases rejected during November.....
3. Total number of cases in which decision not made on November 30.....

## B. CASES ACCEPTED DURING NOVEMBER (see general note):

*Relief Status of Applicant*

PAYMENT OF CLINIC ADMISSION FEES	(a) Receiving public relief*	(b) On WPA†	(c) Not receiving (a) public relief * or (b) WPA†	(d) Total
1. Patient paying full clinic admission fees				
2. Free care				
Total accepted cases (see general note)				
C. CASES REJECTED DURING NOVEMBER (see general note)				
<i>Reason for Rejection:</i>				
1. Patient can afford private physician				
2. Private physician will treat free or give credit				
3. Clinic care not needed				
4. Already under care in another clinic				
5. Referred to other clinic (voluntary hospital)				
6. Referred to other clinic (public hospital)				
7. Lack of facilities (clinics overcrowded)				
8. Other				
Total rejected cases (see general note)				



## D. TOTAL NUMBER OF PATIENTS TREATED AND CLINIC VISITS DURING NOVEMBER 1939:

	No. of patients	No. of visits
1. Full payment of clinic admission fees		
2. Free		
Total		

## E. PAYMENT FOR PRESCRIPTIONS, APPLIANCES AND OTHER SERVICES DURING NOVEMBER 1939:

	No. of patients
1. Full payment by patient of clinic charges for prescriptions, appliances and other services	
2. Partial payment by patient of clinic charges for prescriptions, appliances and other services	
3. Prescriptions, appliances and other services given entirely free	
4. Payment for prescriptions, appliances and other services by Department of Welfare	
Total	

*General note on Cases Accepted and Rejected in November:*

Do not count cases more than once. Total of lines B-1, and 2, and total of Columns B-(a), (b) and (c) should each equal the total number of patients accepted for clinic care during the month. Similarly under C, the total of lines 1-8 and total of columns (a), (b) and (c) should each equal the total number of rejected cases during the month.

*Explanatory notes on "Relief Status of Applicant":*

\* "(a) Receiving public relief."

Enter cases where, according to applicant's statement, he as an individual or as a member of a family, is receiving any form of public relief such as home relief, veteran relief, old age assistance, assistance to the blind, aid to dependent children, care in a boarding home or in an institution.

† "(b) On WPA."

Enter cases where the applicant states that he is working on WPA or was working on WPA immediately prior to this illness, or that a member of his family is currently working on WPA. If a WPA recipient is also receiving home relief, classify such a case under WPA only.

Return form when completed to:

Temporary Legislative Commission to Formulate a Long Range State Health Program,  
346 Broadway, New York, N. Y.

**Appendix L**  
**STATE OF NEW YORK**  
**No. 1521**  
**IN ASSEMBLY**  
**February 13, 1940**

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Int. 1420

Introduced by Mr. MAILLER—(at request of New York State Temporary Commission to Formulate a Health Program)—read once and referred to the Committee on Public Education

AN ACT to amend the education law, in relation to internship as a condition prerequisite to receiving a license to practice medicine

*The People of the State of New York, represented in Senate and Assembly, do enact as follows:*

Section 1. Subdivision four of section twelve hundred and fifty-six of chapter twenty-one of the laws of nineteen hundred nine, entitled "An act relating to education, constituting chapter sixteen of the consolidated laws," as amended by chapter one hundred and forty of the laws of nineteen hundred ten, such section having been added by chapter eighty-five of the laws of nineteen hundred twenty-seven and such subdivision having been amended by chapter one hundred and fifty-seven of the laws of nineteen hundred thirty, is hereby amended to read as follows:

4. Has completed not less than four satisfactory courses of at least eight months each in a medical school in this country or Canada registered as maintaining at the time a standard satisfactory to the department, or in a medical school in a foreign country maintaining a standard not lower than that prescribed for medical schools in this state, *and has completed an internship of not less than twelve months in a hospital in this country or Canada approved and registered as maintaining at the time a standard satisfactory to the commissioner of education and the state board of medical examiners.* In lieu of the first two years of such medical course the department may accept evidence of graduation with the degree of bachelor or doctor of dental surgery from a registered dental school in which the requirements for admission were the same as those prescribed for a registered medical school, and in which the course of instruction included all of the minimum requirements prescribed for the first two years of the course in a registered medical school. New York medical schools and New York medical students shall not be discriminated against by the registration of any school out of the state whose minimum graduation standard is less than that fixed by the statute for New York medical schools. The department may accept as the equivalent for any part of the third and fourth requirement, evidence of five or more years' reputable practice, provided that such substitution be specified in the license, and, as the equivalent of the first year of the fourth requirement, evidence of graduation from a registered college course, provided that such college course shall have included not less than the minimum requirements prescribed by the department for such admission to advanced standing. The department may admit conditionally to the examination in anatomy, physiology, and chemistry, applicants nineteen years of age, certified as having studied medicine not less than two years, including two satisfactory courses of at least eight months each in two different calendar years in a

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EXPLANATION—Matter in *italics* is new.

medical school registered as maintaining at the time a standard satisfactory to the department, provided that such applicants meet the second and third requirements of this section.

§ 2. Subdivision five of section twelve hundred and fifty-six of such chapter, as added by chapter eighty-five of the laws of nineteen hundred twenty-seven, is hereby amended to read as follows:

5. Has received the degree of bachelor or doctor of medicine from some medical school in this country or Canada, registered as maintaining at the time a standard satisfactory to the department, or a medical degree or diploma from a medical school in a foreign country maintaining a standard not lower than that prescribed for medical schools in this state, or a license to practice medicine in a foreign country issued under requirements not lower than those exacted for a medical license in this state, unless admitted conditionally to the examinations as specified above, *and has completed an internship of not less than twelve months in a hospital in this country or Canada approved and registered as maintaining at the time a standard satisfactory to the commissioner of education and the state board of medical examiners.*

The degree of bachelor or doctor of medicine shall not be conferred in this state before the candidate has filed with the institution conferring it the certificate of the department that before beginning the first annual medical course counted toward the degree, he had earned a medical student qualifying certificate in accordance with the rules of the department.

§ 3. Section twelve hundred and fifty-nine of such chapter, as added by chapter eighty-five of the laws of nineteen hundred twenty-seven and amended by chapter two hundred and sixty-two of the laws of nineteen hundred twenty-nine, is hereby amended to read as follows:

§ 1259. Licenses. On receiving from the state board an official report that an applicant has successfully passed the examinations and is recommended for license, the department shall issue to him a license to practice according to the qualifications of the applicant. Every license shall be issued by the department under seal and shall be signed by the president and secretary of the board and by the officer of the department who approved the credentials which admitted the candidate to examination, and shall state that the licensee has given satisfactory evidence of fitness as to age, character, preliminary and medical education and all other matters required by law, and that after full examination he has been found properly qualified to practice. There shall be issued to applicants who, when admitted to the licensing examination, were citizens of a foreign country, and who had declared intention of becoming citizens of the United States, upon passing the examination, a license but upon failure of such licensee within ten years from the date of such declaration of intention to furnish evidence of his having actually become a citizen his license shall terminate and his registration shall be annulled. Applicants examined and licensed by other state examining boards registered heretofore by the regents or hereafter by the department as maintaining standards not lower than those provided by this article and applicants who matriculated in a New York state medical school before June fifth, eighteen hundred and ninety, and who received the degree of doctor of medicine from a registered medical school before August first, eighteen hundred and ninety-five, may without further examination, on payment of twenty-five dollars to the department and on submitting such evidence as they may require, receive from them an endorsement of their licenses or diplomas conferring all rights and privileges of a license issued by the department after examination. The commissioner of education may in his discretion on the approval of the board of regents indorse a license or diploma of a physician from another state, or country, provided the applicant has met all the preliminary and professional qualifications required for earning a license on examination in this state, *except the qualification of the completion of an internship of not less than twelve months in a hospital in this country or Canada approved and registered as maintaining at the time a standard satisfactory to the commissioner of education and the state board of medical examiners*, has been in reputable practice for a period of ten years, and has



reached a position of conceded eminence and authority in his profession. Any physician, who was actually engaged in the practice of medicine in this state prior to September first, eighteen hundred and ninety-one, and who failed to register, although eligible to do so at the time, or any physician, whose registration is not legal because of some error, misunderstanding or unintentional omission, may on the unanimous recommendation of the state board of medical examiners that he has submitted satisfactory proof of having complied with all the requirements prescribed by law at the time of his failure to register of his incomplete registration, receive from the department under seal a certificate of the facts which may be registered in accordance with this article. Before any license is issued it shall be numbered and recorded in a book kept in the office of the department, and its number shall be noted in the license; and a photograph of the licensee filed with the records. This record shall be open to public inspection, and in all legal proceedings shall have the same weight as evidence that is given to a record of conveyance of land.

§ 4. This act shall take effect July first, nineteen hundred forty-two.

## Appendix M

### STATE OF NEW YORK

No. 2487

Int. 2158

### IN ASSEMBLY

March 8, 1940

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Introduced by Miss TODD—(at request of New York State Temporary Commission to Formulate a Health Program)—read once and referred to the Committee on Public Education

AN ACT to amend the education law, in relation to the practices and activities exempted from the provisions of article forty-eight thereof relating to the practice of medicine

*The People of the State of New York, represented in Senate and Assembly, do enact as follows:*

Section 1. Subdivision one of section twelve hundred and sixty-two of chapter twenty-one of the laws of nineteen hundred nine, entitled "An act relating to education, constituting chapter sixteen of the consolidated laws," as amended by chapter one hundred and forty of the laws of nineteen hundred ten, such section having been added by chapter eighty-five of the laws of nineteen hundred twenty-seven and amended by chapter four hundred and ninety of the laws of nineteen hundred twenty-seven, is hereby amended to read as follows:

1. This article shall not be construed to affect or prevent the following: (1) The practice of medicine in this state in obedience with the requirements of the laws of the United States of any commissioned medical officer serving in the United States army, navy, or public health service while engaged in the performance of the actual duties prescribed for him under the United States statutes; or (2) the practice of medicine in a legally incorporated hospital by a physician duly appointed as member of the resident staff or by an [interne] intern while actually serving in a state hospital or other state institution in which medical service is [provided] furnished, provided the said duly appointed member of the resident staff or intern has completed not less than four satisfactory courses of at least eight months each in a medical school in this country or Canada registered as maintaining at the time a standard satisfactory to the department, or in a medical school in a foreign country maintaining a standard not lower than that prescribed for medical schools in this state, or has received the degree of bachelor or doctor of medicine from some medical school in this country or Canada, registered as maintaining at the time a standard satisfactory to the department, or a medical degree or diploma from a medical school in a foreign country maintaining a standard not lower than that prescribed for medical schools in this state, or a license to practice medicine in a foreign country issued under requirements not lower than those exacted for a medical license in this state; or (3) the practice of medicine by any physician duly licensed to practice medicine in a neighboring state, who resides near a border of such neighboring state, whose practice extends into this state and who does not open an office or appoint a place to meet patients or receive calls within this state; or (4) any lawfully qualified physician in other states or countries meeting

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EXPLANATION—Matter in *italics* is new; matter in brackets [ ] is old law to be omitted.

legally registered physicians in this state in consultation; or (5) the furnishing of medical assistance in case of emergency; or (6) the domestic administration of family remedies; or (7) the practice of chiropody, dentistry, veterinary medicine or optometry, provided those practicing are legally authorized and licensed under the laws of this state so to do; or (8) the practice of religious tenets of any church; or (9) the selling of lenses, artificial eyes, limbs, or other apparatus or appliances by any persons or manufacturer of the same; or (10) *medical students performing clinical clerkships or similar functions in a legally incorporated hospital, state hospital or other state institution, provided such students are matriculated and enrolled in a medical school in this country or Canada registered as maintaining at the time a standard satisfactory to the department, or in a medical school in a foreign country maintaining a standard not lower than that prescribed for medical schools in this state.*

§ 2. This act shall take effect July first, nineteen hundred forty-two.



## Appendix N

STATE OF NEW YORK

### TEMPORARY LEGISLATIVE COMMISSION TO FORMULATE A LONG RANGE STATE HEALTH PROGRAM

ROOM 412, CAPITOL

ALBANY, N. Y.

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*December 27, 1939*

DEAR SIR:

The New York State Temporary Legislative Commission to Formulate a Long Range State Health Program is interested in obtaining information concerning the availability of internships and residencies at general hospitals in New York State particularly at those hospitals which are not listed by the American Medical Association as approved for the training of interns.

May we solicit your assistance in supplying the Commission with the information called for in the short questionnaire which is attached? It is not necessary to supply the names of interns or residents but we would like to know the name of the medical school together with the date of graduation for each intern and whether such intern or resident has had previous intern training of at least one year in a hospital approved by the American Medical Association for the training of interns.

Your kind cooperation in this matter will be greatly appreciated and will assist materially in the work of the Commission.

Very truly yours,

LEE B. MAILLER,

*Chairman*

(Enclosure)



## Appendix O

### STATE OF NEW YORK

No. 2726

Int. 2252

### IN ASSEMBLY

March 29, 1939

Introduced by Mr. WAGNER—read once and referred to the Committee on Ways and Means

AN ACT to provide for the establishment and administration of a system of health insurance, constituting chapter forty-five-a of the consolidated laws

*The People of the State of New York, represented in Senate and Assembly, do enact as follows:*

#### CHAPTER 45-A OF THE CONSOLIDATED LAWS

##### HEALTH INSURANCE LAW

Article 1. Short title; legislative findings; definitions. (§§ 1-3.)

2. Health insurance board. (§§ 10-16.)

3. Health insurance fund. (§§ 20-25.)

4. Benefits. (§§ 30-34.)

5. Miscellaneous. (§§ 40-45.)

#### ARTICLE I

##### SHORT TITLE; LEGISLATIVE FINDINGS; DEFINITIONS

Section 1. Short title.

2. Legislative findings.

3. Definitions.

Section 1. Short title. This chapter shall be known and may be cited as the "Health Insurance Law."

§ 2. Legislative findings. The legislature hereby finds and declares as the policy of the state that the health of the people of the state is a matter of state concern; that ill health is a major cause of suffering, economic loss and dependency; that good health is essential to the security and progress of the state; that there is in existence serious, unmet needs for medical services; that there are serious inequalities of resources, medical facilities and services for different economic groups; that these inequalities create handicaps for the parts of our state and the groups of our people which most sorely need the benefits of modern medical science; that the present efforts of the medical profession in providing medical care should be supplemented by the state and local governments in order to make available in all parts of our state and for all groups of our people the scientific knowledge and skill at our command to prevent and care for sickness and disability; to safeguard mothers,

EXPLANATION — Matter in *italics* is new; matter in brackets [ ] is old law to be omitted.



infants, and children; and to offset through social insurance the loss of earnings among workers who are temporarily or permanently disabled.

§ 3. Definitions. As used in this chapter:

1. "Board" means the state board of health insurance established by this chapter in the department of health.

2. "Fund" means the health insurance fund established by this chapter.

3. "Employer" means any person, partnership, firm, association, public or private corporation, the legal representatives of a deceased person or the receiver, trustee, or successor of a person, partnership, firm, association, public or private corporation including the state, municipal corporations, other governmental subdivisions, except the government of the United States, and all other public agencies and authorities, employed in any employment as defined by this chapter. Whenever any helper, assistant or employee of an employer engages any other person in the work which said helper, assistant or employee is doing for the employer, such employer shall for all purposes hereof be deemed the employer of such other person, whether such person is paid by the said helper, assistant or employee, or by the employer, provided the employment has been with the knowledge, actual, constructive, or implied of the employer.

4. "Employee" means any person, including aliens and minors, employed for hire by an employer in an employment as defined by this chapter, except any person employed at other than manual labor receiving wages in excess of two thousand five hundred dollars a year, and except minor children employed by their parent or parents and persons engaged in the performance of religious services for a religious institution.

5. "Employment" means any employment of an employee by an employer in which all or the greater part of the employee's work is performed within the state under any contract of hire, express or implied, oral or written, and shall include any trade, occupation, service or profession in which any person may engage.

6. "Wages" means every form of remuneration received by an employee on account of his labor including wages, salaries, commissions, bonuses, gratuities, the reasonable money value of board, rent, housing, lodging, or similar advantages.

7. "Full-time daily wages" means the daily wages that an employee would receive at current rates but for his disability. The board may make such rules and adopt such methods of calculating full-time daily wages as may be suitable and reasonable under this article and under the conditions prevailing in this state.

8. "A day of employment" means any day in which an employee has had employment for all or any part of the day with an employer and in an employment as defined by this chapter.

9. "Disability" means the inability of an employee because of sickness or injury, to continue in the employment in which he is then engaged, though such employment is not one within the definition of this chapter; or if the employee is then unemployed, the inability, because of sickness or injury, to accept immediately available work in any employment for which he is reasonably fitted by training and experience including employments not within the definition of this chapter. In no case shall disability be deemed to exist if any employee engages in any gainful occupation.

10. "Loss due to disability" means a total lack of wages because of disability.

11. "Disabling sickness or injury" means any sickness or injury causing disability.

12. "Appropriate premium" means the combined amount payable by the employer, employee, and the state on account of the insurance of a compulsorily insured employee.

## ARTICLE II

## HEALTH INSURANCE BOARD

## Section 10. Creation of board.

11. Duties and powers of board.
12. State advisory councils.
13. Public welfare districts.
14. Remuneration.
15. Claims for benefits.
16. Freedom of choice.

§ 10. Creation of board. 1. There is hereby established in the department of social welfare a health insurance division, at the head of which shall be the state health insurance board to consist of five members who shall be appointed by the governor by and with the advice and consent of the senate. At least two of the members of such board shall be duly licensed physicians. Of the members first appointed one shall be appointed for a term of two years, two for a term of four years and two for a term of six years and their successors shall be appointed for terms of six years each, except that a member chosen to fill a vacancy existing by a reason other than the expiration of a term shall be appointed for the unexpired term of the member whose vacancy he fills. The governor shall designate one member to serve as chairman of the board. Any member of the board may be removed by the governor for inefficiency, neglect of duty, misfeasance or malfeasance in office or for other good and sufficient cause after giving to such member a copy of the charges against him and a reasonable opportunity to be heard, either in person or by counsel, in defense.

2. A vacancy in the board shall not impair the right of the remaining members to exercise all of the powers and perform all of the duties conferred and imposed upon the board by this chapter. Three members of the board shall constitute a quorum for the transaction of business.

3. The board shall make an annual report to the state commissioner of health and the governor summarizing the work of the board and the benefits derived from the operations of this chapter during the preceding calendar year and such recommendations as it may see fit to make.

4. Each member of the board shall receive a salary of ten thousand dollars per year. The board may appoint an executive director, district medical superintendents and such other employees as it may require for the proper administration of the provisions of this chapter and may fix the salaries and prescribe the duties of all such employees. The reasonable and necessary traveling and other expenses of the members of the board and of the other officers and employees of the board actually and necessarily incurred by them in the performance of their duties hereunder shall be paid from the state treasury out of appropriations made available therefor, upon the audit and warrant of the comptroller, on vouchers approved by the chairman of the board. Physicians rendering medical services pursuant to the provisions of this chapter shall not be regarded as employees or officers of the board.

5. The principal office of the board shall be in the city of Albany. The board may also meet and exercise any or all of its powers at any other place within the state.

§ 11. Duties and powers of the board. The board shall enforce and administer this chapter and shall have all the duties, powers and authorities imposed and granted by this chapter. In addition, it shall have the following duties and powers: (a) To establish standards of administration throughout the state, to make all such rules and regulations as may be required for the administration and enforcement of this chapter, and to amend and modify any of its rules and regulations from time to time as it may find necessary or desirable;

(b) To supervise, control and make inquiries into the administration of this chapter and the furnishing and payment of the benefits therein provided and to do all things it deems necessary or proper to improve the same throughout the state or in any part thereof;

(c) After a hearing on written charges, to remove any physician or dentist in general practice, surgeon, other medical or dental specialist, hospital, clinic, laboratory or other person or agency from the list of those who have agreed or with whom arrangements have been made to furnish medical benefits, when the continued inclusion of such person or agency would be prejudicial to the adequate, proper or efficient furnishing of the medical benefits. Regulations for all disciplinary action affecting physicians and dentists who fraudulently or negligently violate the terms of insurance service under this article, shall be adopted by the board after consultation with the appropriate professional associations;

(d) To make inquiries into the causes and results of sickness and injuries, the causes of mortality and the effect of localities, employments and other conditions upon the health of the persons entitled to the benefits provided by this chapter. To obtain, collect, preserve and from time to time, publish such information relating to mortality, sickness, injury and health as may be useful in the administration of this chapter or may contribute to the promotion of health or the security of life;

(e) To promote the health and safety of the persons entitled to the benefits provided by this chapter and to take such steps within its means as it may deem feasible and appropriate to reduce and prevent sickness, injury and death among such persons;

(f) To cooperate with public health officers and all other agencies, public and private in the improvement of public health and sanitation and in the promotion of public education in all matters pertaining to health;

(g) If, in its opinion the purposes of this chapter will thereby be furthered or the furnishing of the medical benefits therein provided more adequately secured and, if the surplus and reserves of that portion of the fund which bears the cost of the medical benefits justify such action, it may make contributions or donations to hospitals, laboratories, clinics or other agencies engaged in furnishing the medical benefits not operated for profit, or for medical research, subject to such conditions as may be agreed upon, and any sums so expended shall be considered as part of the cost of the administration of the medical benefits provided by this chapter;

(h) To adopt rules and regulations governing contested claims for benefits under this chapter. Referees shall be appointed to hear and decide such claims in the various districts and the claimant shall be entitled to appeal to a central appeal body which shall be set up by the Board.

§ 12. State advisory councils. 1. There is hereby created a state general advisory council of twelve members to be appointed by the governor. Three of the appointees to this council shall be persons who on account of their previous vocations, employments or affiliations can be classed as representatives of employers; three appointees shall be persons who, on account of their previous vocations, employments, or affiliations, can be classed as representatives of employees; three appointees shall be persons representative of the professions furnishing the medical benefits; and three appointees shall be persons representative of the public. One representative of the employers, one representative of the employees, one representative of the professions and one representative of the public shall be appointed for a term of two years; one representative of the employers, one representative of the employees, one representative of the professions and one representative of the public shall be appointed for a term of four years; and one representative of the employers, one representative of the employees, one representative of the professions and one representative of the public shall be appointed for a term of six years. Thereafter, as their tenures expire, the governor shall appoint or reappoint members for the term of six years. The council shall consider and shall advise the board upon all matters connected with the administration of this chapter and of the benefits provided therein submitted to it by the board and may recommend upon its own initiative such changes in the administration of this chapter and of the benefits provided therein as it deems necessary.

2. There is hereby created a state medical advisory council of nine members to be appointed by the governor. The appointees to this council shall be so selected that the council may be representative of the physicians and den-



tists in general practice, the surgeons, the other medical and dental specialists, the pharmacists, the hospitals, laboratories, clinics and nurses. Three shall be appointed for a term of two years; three shall be appointed for a term of four years; and three shall be appointed for a term of six years. Thereafter as their terms expire the governor shall appoint or reappoint members for the term of six years. The said council shall consider and shall advise the board upon all matters connected with the administration of the medical benefits provided in this chapter submitted to it by the board and may recommend upon its own initiative such changes in the administration of said benefits as it deems necessary.

3. The members of both of said councils shall be appointed within thirty days after the enactment of this chapter. The governor may at any time remove a member of either council for cause after a hearing on written charges. The members of both councils shall serve without salary, but shall be allowed actual and necessary traveling and other incidental expenses.

§ 13. Public welfare districts. The board may utilize the public welfare districts of the state as appropriate districts for the administration of this article and shall in each such district make arrangements for the providing of the medical cash and maternity benefits hereinbefore prescribed. The administrative officers in such district shall include a district medical superintendent, who shall be a licensed physician of at least five years experience in general practice. Every licensed physician and surgeon shall be permitted to enter the general practitioner medical service provided under this article, if willing to accept the terms and conditions of service as laid down by the board and each insured person shall be permitted to select and at reasonable intervals to change such general practitioner under rules laid down by the board.

§ 14. Remuneration. 1. The board shall fix in each district the manner of remunerating physicians and dentists in general practice, surgeons, and other medical and dental specialists, pharmacists, nurses, hospitals, clinics, laboratories, and other persons and agencies furnishing the medical benefits after consultation with the appropriate professional organizations in each instance. No mode of remunerating physicians and dentists in general practice shall be adopted for any local area within the state without the consent of a majority of such physicians or such dentists, respectively, in that locality, unless the majority of such physicians or dentists fail to agree upon any method of payment.

2. Any one of the following modes may be adopted for remunerating physicians and dentists in general practice: (a) A salary system;

(b) A per capita system whereunder payment will be based on the number of persons entitled to medical benefits included in the practitioner's list;

(c) A fee system whereunder payment will be based on the extent and character of the treatment given and services rendered by the practitioner to persons entitled to medical benefits; and

(d) Any combination or modification of the systems herein above stipulated.

§ 15. Claims for benefits. 1. Any person claiming benefits shall, in accordance with such rules as the board may prescribe, file a certificate of disability signed by the physician in charge of his case. A person claiming benefits shall give notice of his continuing right to such benefits as often and in such manner as shall be prescribed by the board.

2. Any person claiming cash or maternity benefits shall for the time that such benefits are claimed correctly report any wage-earning employment had during such time and any wages received for such employment, including employments not within the definition of this article, and shall make such reports in accordance with such rules as shall be prescribed by the board.

§ 15. Freedom of choice. 1. Every duly qualified physician and dentist engaged in general practice, who so desires, shall have the right to be included in the list of those furnishing the medical benefits provided for by this chapter, subject to being remunerated for his services in the manner fixed by the board.

2. Every person entitled to the medical benefits provided for by this chapter shall have the right, in such form as the board shall prescribe, to select the

physician engaged in general practice and the dentist engaged in general practice by whom he wishes to be attended and treated, subject to the consent of the practitioner so selected, and the right at any time to change the selection so made on such notice as the board may prescribe.

3. The board shall cause to be distributed on an equitable basis among the several physicians and dentists in general practice who have signified their desire to furnish the medical and dental care provided for by this chapter in accordance with the rules and regulations prescribed by the board, those persons entitled to the medical benefits provided herein who, after due notice have failed to select a physician or dentist in general practice or have been refused by the practitioner whom they have selected.

## ARTICLE III

### HEALTH INSURANCE FUND

#### Section 20. Creation of fund.

21. Accrual of premiums.
22. Employers' premiums.
23. Employees' premiums.
24. State premiums.
25. Voluntary insurance.

§ 20. Creation of fund. 1. There is hereby created and established a health insurance fund out of which benefits under this chapter shall be paid. The fund shall consist of all contributions and appropriations made in accordance with the provisions of this chapter; of property and securities acquired by and through the use of monies belonging to the fund; and of interest and other income earned by the fund.

2. The state commissioner of taxation and finance shall be the custodian of the fund and all disbursements therefrom shall be paid by him upon vouchers of the board. Any portion of the fund not needed for immediate use shall be deposited in the same manner and subject to all provisions of law with respect to the deposit of other state funds held by him; and all interest earned by such portion of the fund as may be so deposited shall be collected and placed to the credit of the fund. Any of the surplus or reserve belonging to the fund may, by order of the board, approved by the state commissioner of taxation and finance, be invested in any obligations of the United States of America or any agency thereof or in obligations of the state or agency thereof.

§ 21. Accrual of premiums. On and after the first day of October, nineteen hundred thirty-nine, premiums shall accrue and become payable to the fund by every employer and employee subject to this chapter and by the state, in accordance with the provisions of this chapter. All premiums shall be paid or remitted at regular intervals, at such times and in such manner as the board shall prescribe to the state commissioner of taxation and finance, who shall credit the same to the fund.

§ 22. Employers' premiums. Every employer shall pay into the fund: (a) Amounts equal to three per centum of the total of all wages periodically paid by him to employees who receive wages of twenty dollars a week or less; and (b) Amounts equal to two per centum of the total of all wages periodically paid by him to employees who receive wages in excess of twenty dollars a week but less than forty dollars a week; and

(c) Amounts equal to one per centum of the total of all wages periodically paid by him to employees who receive in excess of forty dollars a week.

§ 23. Employees' premiums. 1. Every employee shall pay into the fund: (a) Amounts equal to one per centum of the total of all wages periodically received by him from an employer if such wages do not exceed twenty dollars a week;

(b) Amounts equal to two per centum of the total of all wages periodically received by him from an employer if such wages are in excess of twenty dollars a week but do not exceed forty dollars a week;

(c) Amounts equal to three per centum of the total of all wages periodically received by him from an employer if such wages are in excess of forty dollars a week.

2. Such amounts shall be deducted by the employer from the employees' wages and shall be remitted by the employer to the state commissioner of taxation and finance and until so remitted shall be set apart and held as trust funds.

3. No agreement by an employee to pay any portion of the premiums required to be paid by his employer shall be valid, and no employer shall make a deduction for such purpose from the wages of an employee, or in any other manner collect from an employee any portion of the premiums required to be paid by his employer.

§ 24. State premiums. The state shall pay into the fund amounts equal to one per centum of the total of all wages periodically paid by employers to employees provided that the sum payable by the state shall be reduced by the amount made available to the state for such purposes by the government of the United States.

§ 25. Voluntary insurance. 1. Every person not employed in an employment within the definition of this article, who is not older than sixty-five years, who is dependent upon his earnings and is physically able to earn his living shall be entitled voluntarily to insure himself on the same conditions for all the health insurance benefits or any one or more of said benefits regularly provided for employees compulsorily insured under this chapter.

2. A health examination may be required as a condition to obtaining such voluntary insurance, only of a person who within the three years preceding application for such insurance has not had at least two hundred days of employment.

3. A voluntarily insured person insured for all health insurance benefits shall pay as his contribution four-fifths of the appropriate premium. A voluntarily insured person who is insured for one or more but not all of the health insurance benefits shall pay four-fifths of the contribution fixed by the board as the appropriate premium for such limited insurance. The state shall pay in each case the difference between the voluntarily insured person's contribution and the appropriate premium. In computing the amount payable by a voluntarily insured person, there shall not be considered any income received by such voluntarily insured person in excess of three thousand dollars per annum.

4. Persons who are receiving old-age or unemployment benefits or relief from any governmental or public officer or agency or who are over sixty-five years of age or over, and during the greater part of the twenty year period between the ages of forty-five and sixty-five years either have been employed or would have been eligible to voluntary insurance within the purview of this chapter, may be insured voluntarily, if such person, or if such officer or agency regularly pays into the fund such amounts as may be fixed by the board, which amounts shall be fixed so as most equitably to rate the risk and distribute the cost of benefits involved. However, no person sixty-five years of age or over shall be insured for cash benefits.

## ARTICLE IV

### BENEFITS

#### Section 30. Cash benefits.

31. Maternity benefits.
32. Medical benefits.
33. Waiver of assignment of benefits.
34. Notice of disability.

§ 30. Cash benefits. 1. Cash benefits shall be paid to an employee who is under sixty-five years of age and is qualified as insured for cash benefits for loss due to disability, after an uncompensated waiting period of seven days, at the rate of fifty per centum of the employees' full-time wages, if the employee has no dependent wife or children. The maximum of such benefits



shall be twenty dollars a week. To this benefit shall be added an additional ten per centum of the employees' full time wages, up to a maximum of five dollars a week, for a dependent spouse, and an additional five per centum of the employees' full time wages, up to a maximum of three dollars a week, for each dependent child, not exceeding four. Such cash benefit shall be payable for a maximum of one hundred and fifty-six cumulated days of loss due to disability in each consecutive fifty-two weeks. No cash benefit shall be paid for loss due to disability for which the employee is entitled to money benefits under any workmen's compensation law.

2. To qualify as insured for cash benefits, the insured must have had one hundred days of employment or of voluntary cash insurance within the twelve months preceding the day on which the claim for cash benefits is made or, in the alternative, not less than one hundred and sixty such days within the twenty-four months preceding said day.

3. An employee who is not qualified as insured for cash benefits in accordance with paragraph two of this section, shall be qualified as insured for cash benefits at half rate during an extended period equal to one day for every five days of employment or of voluntary cash insurance during the preceding five years, should he suffer a loss due to disability during the extended period.

§ 31. Maternity benefits. 1. Cash maternity benefits shall be paid to a woman employee for six weeks prior to the birth of a child and for six weeks after the birth of a child, in amounts equal to the cash benefits which such employee would be entitled to receive for loss due to disability. Such benefit shall be paid only on condition that the employee refrains from all gainful occupation during said period and has received prenatal care.

2. To qualify as insured for cash maternity benefit an employee shall be required to have no less than two hundred and fifty days of employment or voluntary cash insurance during the twenty-four months preceding the day on which the said benefit is to commence.

3. The period during which the cash maternity benefit is paid shall not be included within the maximum period for which the employee is entitled to receive cash benefits for loss due to disability.

4. Women employees, on ceasing to be qualified as insured for cash maternity benefit, shall have the same right of extension of qualification for insurance for cash maternity benefit at half-rate as that granted to employees with respect to their qualifications for cash benefits for loss due to disability in accordance with the provision of paragraph three of section thirty.

§ 32. Medical benefits. 1. Medical benefits shall be provided for employees, the dependent spouses, and dependent children and such other members of their family who are dependent on them and live in the same household.

2. Medical benefits shall be provided immediately on the occurrence of sickness or injury and to qualify as insured for such benefits an employee must have had one hundred days of employment or of voluntary medical insurance within the twelve months, or one hundred and fifty days within the twenty-four months, preceding the day on which the furnishing of medical benefits is asked for him or any of his dependents. Medical benefits shall be provided without time limit, so long as the person through whose eligibility they are granted remains insured for such benefit.

3. Medical benefits need not be provided for any person in respect to any disability for which such person is entitled to medical treatment under any workmen's compensation law.

4. Medical benefits shall consist of:

(a) The service of a physician in general practice at the office, home, hospital, or elsewhere, in preventive diagnostic, and therapeutic treatment and care, which shall include immunization and periodic physical examinations.

(b) On the prescription of the physician in charge, and the approval of the district medical superintendent,

(1) General and special hospital treatment and care which include nursing and other usual hospital services;

(2) Prenatal and maternity treatment and care in the home or in the hospital;

(3) The services of a surgeon, diagnostician, or other specialist at the office, home, hospital or elsewhere;

## (4) The service of laboratories and clinics;

(5) The services of a dentist in general practice in such treatment and care, including restorative work, as may be found necessary to correct conditions which are seriously prejudicial to health, or are causing or threatening to cause disability, or are interfering or threatening to interfere with the pursuit of a gainful occupation.

(c) Additional medical benefits other than those hereinbefore stipulated may be furnished entirely at the expense of the fund or partly at the expense of the fund or partly at the expense of the fund and partly at the expense of the persons receiving such additional medical benefits, if and when there is accumulated a surplus reserve beyond that required by the rules of the board.

5. In any emergency, the foregoing benefits (b) one to (b) five, inclusive may be provided on the prescription of the physician in charge without prior approval of the district medical superintendent.

§ 33. Waiver of benefits. No agreement by an employee to waive any right or benefit under the system established by this chapter shall be valid; nor shall benefits be assigned, pledged, encumbered, released or commuted, and such benefits shall be exempt from all claims of creditors and from levy, execution, and attachment or other remedy now or hereafter provided for recovery or collection of a debt, which exemption may not be waived.

§ 34. Notice of disability. 1. Any person claiming benefits shall, in accordance with such rules as the board may prescribe, file a certificate of disability signed by the physician in charge of his case. A person claiming benefits shall give notice of his continuing right to such benefits as often and in such manner as shall be prescribed by the board.

2. Any person claiming cash or maternity benefits shall for the time that such benefits are claimed correctly report any wage-earning employment had during such time and any wages received for such employment, including employments not within the definition of this article, and shall make reports in accordance with such rules as shall be prescribed.

## ARTICLE V

## MISCELLANEOUS

## Section 40. Penalties.

41. Subrogation.
42. Separability.
43. Appropriation.
44. Federal assistance.
45. Effective date.

§ 40. Penalties. A person who wilfully makes a false statement or representation to obtain any benefit or payment under the provisions of the system, or to obtain payment or remuneration for services rendered or materials supplied in furnishing any of the benefits provided by the system, either for himself or for any other person, or to lower payments to be made to the fund, or who wilfully refuses or fails to make any payment to the fund; or who fails to set apart and hold as a trust fund the amounts deducted from an employee's wages to pay the contributions required of such employee; or who refuses to allow the board or its authorized representative to inspect payrolls or other records or documents relative to the enforcement and administration of the system; or who makes a deduction from the wages of any employee to pay any portion of the contributions which an employer is required to make or in any other manner collects from an employee any portion of the contributions required to be paid by the employer; or who violates any of the provisions of this article or of any rule or regulation adopted hereunder, or fails, neglects or refuses to perform any duty lawfully imposed upon him or pursuant to this chapter, or fails, neglects, or refuses to obey any lawful order given or made by the board or any judgment or decree made by any court in connection with the provisions of this chapter or any rule or regulation adopted pursuant thereto is guilty of a misde-

meanor and shall, on conviction, be subject to a fine of not less than fifty dollars nor more than five hundred dollars or to imprisonment of not less than sixty days nor more than one year or to both such fine and imprisonment.

§ 41. Subrogation. If any of the benefits provided by this chapter are paid or furnished in the event of sickness, injury, or disability to any person who, by reason of such sickness, injury or disability, has a right or claim for compensation or benefits under any workmen's compensation law or any employer's liability act or otherwise against his employer or any other person for causing such sickness, injury, or disability and for the damages resulting therefrom, the fund, to the extent of the said benefits so paid and the cost thereof so furnished, shall be entitled to reimbursement out of any sum or damages which said person receives by way of compensation or benefits or through suit, settlement or judgment and the fund shall, to said extent, be subrogated to the said right or claim. Upon notice to the one against whom said right or claim exists or is asserted, the amount to which the fund is so entitled by way of reimbursement shall be a lien upon said right or claim and the said sum or damages paid or received thereunder. The board shall enforce this right of subrogation and reimbursement.

§ 42. Separability. If any provision of this chapter or the application thereof to any person or circumstances is held invalid, the remainder of the chapter and the application of such provision to other persons or circumstances shall not be affected thereby.

§ 43. Appropriation. The sum of one hundred fifty thousand dollars (\$150,000), or so much thereof as may be necessary, is hereby appropriated to the board of health insurance in the department of social welfare out of moneys in the state treasury not otherwise appropriated to defray the expenses of such board, including personal service, operation and maintenance, in carrying out the provisions of this chapter. Such moneys shall be payable from the state treasury on the audit and warrant of the comptroller on vouchers approved in the manner prescribed by law.

§ 44. Federal assistance. 1. The board shall submit the plans for medical care and disability compensation provided by this chapter to the social security board established by the federal social security act for approval pursuant to the provisions of such federal act. The board shall make such rules and regulations not inconsistent with law as may be necessary to make such plan conform to the provisions of such federal act and any rules and regulations as adopted pursuant thereto. The board shall make reports to the social security board created by such federal act in the form and nature required by such board and in all respects comply with any request or direction of such board which may be necessary to assure the correctness and verification of such reports.

2. The state commissioner of taxation and finance shall accept and receive any and all grants of money awarded to the state for federal assistance to plans for medical care and disability compensation pursuant to such social security act. All moneys so received shall be deposited by the commissioner of taxation and finance in the state health insurance fund established by this chapter. Such money shall be paid from such fund or funds on audit and warrant of the comptroller upon vouchers of the board.

§ 45. Effective date. This act shall take effect immediately.











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